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ABSTRACT

This document contains presentations on the state of social services and care for the aging in Taiwan, Hong Kong, and the United States given at the 1986 International Conference on Social Service and Aging Policies. Included are a conference statement by T. H. Li, remarks by Shui-teh Hsu, the major of Taipei, and these presentations: (1) "The Value of Cross-Cultural Gerontology" (Harold L. Sheppard); (2) "Determining the Cultural Baseline" (Glen Golterman); (3) "Social Services for the Elderly in Taiwan" (National Association of Volunteers); (4) "Community Services for the Aged in Taipei" (John Lun-Hsun Chang); (5) "Community Support for the Elderly: Factors Influencing the Contribution of the Family" (Nelson W. S. Chow); (6) "The Aged Person's Perspective" (Judith A. S. Altholz); (7) "The Provision of Social Services in the United States" (Kermit Schooler); (8) "The Changing Aging Population: Implications for Social Services" (Maryann Nardone); (9) "The Challenge of Demographic Trends to Family Support Systems for the Elderly" (Edward Jow-Ching Tu); (10) "Family Care of the Aged in the United States" (Jordan I. Kosberg); (11) "Long Term Care Issues in Florida: Some Questions About the Role of the Family" (Richard D. Tucker); (12) "Financing and Delivering Health Care for the Elderly: Problems, Opportunities, and Strategic Response" (F. Edward Ranelli); (13) "The Financing of Long-Term Care" (Stanley Wallach); (14) "The Feasibility of Self-Sponsored Living Patterns by Old People of the Republic of China" (Ming-Cheu Chen and Richard Li-hsin Wang); (15) "Housing: People, Process, and Policy" (Gordon F. Streib); (16) "Migration and Housing: The Florida Experience" (Aaron Lipman); (17) "Advent Christian Village--More Than Housing" (J. Pomeroy Carter); (18) "Elderly Housing: Design Issues and Implications" (John R. McRae); (19) "Geriatric Residential and Treatment Systems: Florida's Unique Mental Health Program for Seniors" (Rowland W. Folensbee); (20) "Housing of Black Aged, Revisited" (Victoria E. Warner); (21) "Governmental Influences on Health Care for the Elderly" (Marie E. Cowart); (22) "The Effect of Government Services on Family Assistance Provided to the Frail Elderly: Research and Implications" (Amanda Barusch); (23) "The Federal Government Perspective" (Margaret Lynn Duggar); (24) "The State Government Perspective" (Lu Marie Polivka-West); (25) "Learning Needs of Older Adults" (Betty Gilkison); (26) "Health Care Marketers Should Map Strategies" (Charles H. Pimlott, Jr.); and (27) "The Market of Senior Citizens" (Warren French). (NB)

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ITERNATIONAL EXCHANGE
ENTER ON GERONTOLOGY
at the UNIVERSITY OF SOUTH FLORIDA

*A Multi-University Consortium*

# SOCIAL SERVICE AND AGING POLICIES:
# TAIWAN, HONG KONG, AND
# THE UNITED STATES

PRESENTATIONS

TAIPEI CONFERENCE
MAY 1986

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at the University of South Florida

1988

# SOCIAL SERVICE AND AGING POLICIES:

## TAIWAN, HONG KONG, AND

## THE UNITED STATES

PRESENTATIONS

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MAY 1986

INTERNATIONAL EXCHANGE
CENTER ON GERONTOLOGY
University of South Florida
Tampa, Florida

# Foreword

The International Exchange Center is pleased to make available the presentations on Taiwan, Hong Kong, and the United States at the May, 1986, International Conference on Social Service and Aging Policies, held in Taipei, Taiwan. This particular publication is being released and distributed on the occasion of, and in time for, the 1988 conference on the same theme and topics and new ones, scheduled for August at the University of West Florida. The 1988 meeting will include research and policy papers regarding not only the three countries represented at the 1986 event, but also on Australia, Japan, Korea, Singapore, and Thailand -- and also the People's Republic of China.

I wish to express here my deep appreciation and that of the International Exchange Center for the substantial support of the 1986 Conference by the Taiwan (ROC) National Association of Volunteers, the Pacific Cultural Foundation, and many other Taiwan groups and agencies. Special mention should be made of Commissioner Hsiu-Hsiung Bai, director of the Taipei Social Affairs Bureau, and his many colleagues who helped to make the Taiwan Conference the vital first step in our continuing efforts at cross-national and cross-cultural understanding and learning about the common bond of the aging process, and its challenge to an ever-growing list of nations in the world.

The 1988 gathering should prove to be another event that will add momentum and motivation to our mutual objective and mission.

Harold L. Sheppard, Director
International Exchange Center
on Gerontology

# Table of Contents

**Foreword** i

**Conference Statement** 1
T.H. Li

**Remarks** 4
HSU Shui-Teh

**The Value of Cross-Cultural Gerontology** 5
Harold L. Sheppard

**Determining the Cultural Baseline** 10
Glen Golterman

**Social Services for the Elderly in Taiwan** 17
National Association of Volunteers

**Community Services for the Aged in Taipei** 26
John Lun-Hsun Chang

**Community Support for the Elderly: Factors Influencing the Contribution of the Family** 52
Nelson W.S. Chow

**The Aged Person's Perspective** 68
Judith A.S. Altholz

**The Provision of Social Services in the United States** 75
Kermit Schooler

**The Changing Aging Population: Implications for Social Services** 84
Maryann Nardone

**The Challenge of Demographic Trends to Family Support Systems for the Elderly** 88
Edward Jow-Ching Tu

**Family Care of the Aged in the United States** 98
Jordan I. Kosberg

**Long Term Care Issues in Florida Some Questions About the Role of the Family** 104
Richard D. Tucker

**Financing and Delivering Health Care for the Elderly: Problems, Opportunities, and Strategic Response** 106
F. Edward Ranelli

**The Financing of Long-Term Care** 109
Stanley Wallach

**The Feasibility of Self-Sponsored Living Patterns by Old People of the Republic of China** 112
Ming-Cheu Chen and Richard Li-hsin Wang

**Housing: People, Process, and Policy** 114
Gordon F. Streib

**Migration and Housing: The Florida Experience** 123
Aaron Lipman

**Advent Christian Village -- More Than Housing** 131
J. Pomeroy Carter

**Elderly Housing: Design Issues and Implications** 147
John R. McRae

**Geriatric Residential and Treatment Systems: Florida's Unique Mental Health Program for Seniors** 152
Rowland W. Folensbee

**Housing of Black Aged, Revisited** 158
Victoria E. Warner

**Governmental Influences on Health Care for the Elderly** 167
Marie E. Cowart

**The Effect of Government Services on Family Assistance Provided to the Frail Elderly: Research and Implications** 175
Amanda Barusch

**The Federal Government Perspective** 188
Margaret Lynn Duggar

**The State Government Perspective** 191
Lu Marie Polivka-West

**Learning Needs of Older Adults** 197
Betty Gilkison

**Health Care Marketers Should Map Strategies** 202
Charles H. Pimlott, Jr.

**The Market Behavior of Senior Citizens** 208
Warren French

# Conference Statement

## Dr. T. H. Li
## Vice President of the Republic of China[*]

I am very much pleased to address the International Conference on Social Service and Aging Policies which the city of Taipei is honored to host. I would like to take this opportunity to congratulate your association for sponsoring this conference and say "Welcome" to our guests who have traveled far to attend the gathering.

The Conference is jointly sponsored by the National Association of Volunteers of the Republic of China, the National Taiwan University, the Bureau of Social Affairs of the Taipei City Government and the International Exchange Center on Gerontology at the University of South Florida. Experts and workers of these sponsoring units have over the years worked indefatigably to promote the welfare of senior citizens through social education and active economic and other services. Their achievements have earned them much admiration and respect.

In recent years, life expectancy in this country has increased considerably due to rapid social and economic development and advancement of medical science. As a result, the number of elderly people has increased from 3 percent of the population in 1971 to 5 percent today. It is predicted that the percentage of senior citizens in the Republic of China will rise to more than 8 percent by the turn of the century. That will make our society what gerontologists call an "aging society." This being the case, planning welfare services for the aged has become an important task in the process of our socio-economic development.

---

[*] Dr. Li has recently been appointed as President of the Republic of China.

According to gerontologists, the services for the aged are wide in scope and varied in form. They include economic security, health care, mental adjustment, social care, special design of homes for the elderly and even educational services for senior citizens. To cope with the increase of elder people in Taiwan, the government and the private sector have launched a series of welfare services for them in recent years. They range from economic security for retirees to medical insurance, education, community clubs and housing services. All these show that both the government and the society at large have attached great importance to the welfare of the aged.

The aging of population in the industrial society of the West occurred earlier than in this country. Consequently, the development of welfare services in Western countries has a much longer history. However, the East and the West can learn from each other despite their cultural differences. Nowadays the social welfare system of the West calls for a greater role of the family in taking care of the elderly. This coincides with the Chinese tradition of respecting senior citizens. Elderly persons have been regarded as the core of Chinese families and are therefore well taken care of by the younger members of their families. This tradition should be of interest to the welfare states of the Western world.

I am happy to see that participants of the symposium include educators, social scientists, psychologists, welfare and medical workers. The theme, "Social Service and Aged Policies," is also a pertinent one. It is my sincere hope that your deliberations will yield results contributing to the advancement of the welfare of the aged.

# Remarks

**HSU Shui-Teh**
**Mayor of Taipei**

As we know, great changes of society have been causing many social problems. Especially in Taiwan, life expectancy is increasing rapidly, and the population of the aged is increasing. All this is benefited by the improved environment, the medical treatment, and the economy's growth. Meanwhile, industrialization tends also to decay traditions and functions of an ancient society. In the past, elders used to be authoritative and carefully served, but now no more the same. And really, we aim at the conflict and endeavor to restore ancient culture to modern life by means of developing welfare schemes. That is, through establishing the Taipei Evergreen Academy and Evergreen Cultural and Recreational Center, trying to help the elders enjoy their household and estate life; and, being able to encourage their knowledge searching, cultivating their interests, and enriching their lives. Finally, making it easy to live in the changing community, and continuing serving others.

# The Value of Cross-Cultural Gerontology

**Dr. Harold L. Sheppard**
**University of South Florida**

Permit me to join my colleagues from Florida and elsewhere in the United States in expressing our heartfelt appreciation of the magnanimous sponsorship of the 1986 Conference by Commissioner Bai and his fellow R.O.C. hosts. I know the many hours they invested to make the meeting into a reality. Our joining together launched a noteworthy project which should stimulate an ongoing process of mutual learning among the countries represented, from Asia and North America. This enterprise should be viewed as a crucial first step in the development of cross-cultural gerontology.

As a student in anthropology many years ago, I was taught to be aware of, and sensitive to, cultural differences and of the difficulties involved in inter-cultural transfers of ideas, practices, and technologies. But I have never believed that differences between cultures and societies make such transfers totally impossible. Adaptation is intrinsic to the human species.

More important, I have never believed that differences are greater than similarities. This principle is far too important to consider merely a observation. Human beings from varying parts of this very small globe in a vast universe of endless universes have much more in common with each other than they have differences. We should not forget that principle, as we continue to work together to carry out projects of joint interest to each other. Furthermore, my experiences in this field of aging over the past 30 years have impressed me with the unifying role of concern with the problems and challenges associated with the aging phenomenon. By unifying, I refer to how these problems and challenges lead people from diverse backgrounds and philosophies to come together on common ground.

The fields of gerontology and demography should impress us with the fact that most, if not all, societies in today's world are undergoing a momentous aging of populations. This population aging may not be taking place literally at the same time everywhere nor at the same pace, but it is nevertheless a compelling force in national and international environments.

In this respect, countries like the United States -- and especially the state of Florida -- have much to learn by observing -- before they disappear -- the patterns in other countries such as R.O.C. that still allow for a relatively high status of the elderly; their importance in the larger family; and in the broader economy. In turn, Taiwan's policymakers and practitioners -- and those from other countries -- may want to study how a state such as Florida, with more than 18 percent of its population 65 and older; more than 25 percent 60 and older -- how Florida responds in the form of laws, regulations, and services to such large proportions and large numbers. The Florida of today is in many ways the prototype of the world of tomorrow. That is one of the reasons that some of us believe that Asia's planners for tomorrow and the officials of today might benefit from closer ties with Florida and with its public and private programs involving the elderly.

Underlying the spirit of our working together there will be, I hope, the viewpoint that the aging of populations in our two regions of the world is actually a sign or proof of progress -- of progress in extending life expectancy, making it possible for more and more women and men to live in a positive way, to become what is called "old."

Every time life styles, public policy, and biomedical contributions make life worthwhile, productive, and healthier for, say, a 40 year-old, that makes possible a young middle-aged man or woman's living on into the age of 60, 70, 80, or older. The life-course road we journey on is irreversible unless, of course, we have imposed on us a counter-revolution in values about the worthwhileness of life and the cultural and religious obligations to preserve and to extend human life in dignity and well-being.

We in the United States are only beginning to face up to the consequences of that progress. To repeat, all of us should be proud of any society in which that progress takes place, and not -- as many individuals are tempted to do -- look upon those consequences only as burdens, catastrophies, hardships, and problems incapable of solution. Once a society or a government and its institutions make the choice to travel on that one-way road, it must accept the responsibility for the consequences especially if a value is also put on economic development and the necessary population policies that positive economic development requires. I refer here, for example, to the R.O.C.'s well-known experience in population planning that has ensured an equally remarkable record in economic growth and prosperity, a record that has become an enviable model for the rest of the world.

That experience, of course, results in making the elderly population a higher proportion of a country's total population. Eventually such a country's economy will require both a healthy productivity in goods and services, and a socio-cultural belief system that bestows respect and dignity, a feeling of usefulness and self-worth to its older population.

Today, in the United States, and indeed throughout Western Europe, there is no absolute certainty that we really have been willing, without question, to accept the consequences of progress in population aging. The recent slowdown in economic affairs, and the experience in limited-growth national expenditure budgets, have produced in many so-called developed countries a reaction against the positive programs and policies for making the life of senior citizens a good one.

We now have, at least in the United States, a new form of what has been called "ageism", a form of prejudice against the elderly. Its newness lies in the fact that among journalists and some other unsophisticated writers, there is a schizophrenic negativism about the aging population: First, it includes an alleged sentiment of envy among many younger Americans. The younger persons presumably envy and are jealous about the improved socio-economic well-being of many millions of older Americans, especially when these young persons come to be told and to believe that their own prospects for income improvements are in doubt. They come to believe that their problems are the result of the progress of the elderly.

Second, and at the same time, they also allegedly resent having so many elderly depending on services and income provision based on taxes upon the general population. Thus, the new ageism sees the elderly either as too comfortable and not deserving of such comfort, or instead as a burden on the rest of the society, unable to take care of themselves.

When all is said and done, the two conflicting negative images are simply different nuances of a bias against the elderly. Both images share in a common envy and/or fear of population aging. Both images, when translated into policy implications, would throw the younger generations in conflict against the older ones. Both images are reinforced by a western philosophy of excessive individualism and narcissism as well as a new questioning of intergenerational obligations -- obligations which constitute the every essence of all social security systems.

How can we in the west reduce and prevent this new ageism? What can we learn from Taiwan and elsewhere in this region?

The topics considered jointly the by 1986 Conference's participants affect and are affected by these moral and philosophical matters. We in the West need the contributions of those in the East to counteract the excessive individualism and the neglect of obligations among and between generations.

The role of government and family; the positive dimensions of aging; housing; health and long-term care; and social services -- all of these topics should be infused with these basic value questions as a motivating spirit in the development of common policy projects that Commissioner Bai, our generous conference host, and I hope will become the bases for future work between us, as well as between the International Exchange Center and other Asian countries.

# Determining the Cultural Baseline

**Glen Goltermann**
**University of South Florida**

If one may assume that a central mission of the academic is to seek truth, I feel I must give you my philosophy of truth. I see truth as having three levels. First, absolute truth, that is, information and constructs which are verified scientifically as irrefutable and have stood the test of time. Second, perceived truth, that is, information or constructs which the public views as true, and in many cases accepts as true, but which may in fact not be true and do not meet the criteria in my first definition. Thinking the world is flat was a perceived truth at a point in time. An example closer to the field of aging study is the perception that Americans discard their elderly and fail to adequately care for them. This perception, held widely by Americans and others, is, in fact, primarily a myth. The third category of truth, in my philosophy, is that of faith. Simply put, faith is that which we believe is true.

I speak from a base of perceived truth. In order to sketch in the parameters of culture baselines, I must impart obvious and simple concepts which we hope will bear contextual discussions. First, I must explain to Americans some of the most basic concepts in the development of Chinese culture.

> Great Man applies himself
> to the fundamentals. For
> once the fundamentals are
> here, the System comes into
> being. It is filial duty
> and fraternal duty that are
> fundamental to Manhood at
> it's best.
> -- Confucius

It is said that the Golden Age of China (prior to 221 B.C.) was a time in which China enjoyed many schools of philosophical and theological thought. However, it was a time of violence, civil war, and little social cohesion. In about 220 B.C., Ch'in annihilated the Six States and later Han annihilated Ch'in. Han was the first emperor to unify all of China, and he was seeking a way in which to maintain control and social order. It is thought that Tung Ch'ung-shu, Han's prime minister, suggested that Han allow no diversity of ethical thought and allow only the teachings of Confucius to prevail. Confucius' ethics were very useful to Han and subsequent emperors because they espoused individual virtue, harmony, peace, and social cohesion. The philosophy was also extremely appealing since it further espoused absolute obedience to the emperor. Thus began the closing of diverse values in China and the sole perpetuation of _Ren-Li_.

There are five fundamental components of _Ren-Li_: Gen-Zen - Emperor to Subjects; Fu-Tz - Father to Son; Fu-Fu - Husband to Wife; Penyou - friends; Chong Di - Brothers. Each of the five have certain special relationship requirements which the others do not have, but each of the five is related to the Whole. If each group fulfills his obligation the the Individual and the Whole, the world will exist with Jzen - Love; Li - manners; and E - justice. _Ren-Li_ sees all of China as a "family" and each individual or organization in that family must be filial to the father, ie., the government. But within the family everyone and everything has a Place; and the Place is both Individual and related to the Whole. It is valued that the Place must be loved, cared for, and respected. If the Place is filial to the

Whole and the Whole is virtuous, the world will exist in peace and harmony. Problems can only occur if individuals are not filial and do not give honor to the persons of higher place.

A critical aspect of Place is that its nature is vertical not horizontal. Thus decisions must always go up and are usually made at the top rather than the bottom. This is very disconcerting for the Westerner who values productivity rather than place. I will refer to these Western values later.

The concepts of Ren-Li, combined with the concept of Place and social training, make for a very interesting social and value system. If you want to become a student of social policy development in China, I suggest you first attempt to understand her basic cultural underpinnings.

> Today, when people call
> a man filial they mean
> that he is supporting his
> parents. But he does as
> much for his dogs and
> horses! If he does not
> show respect for his
> parents how is he
> differentiating between
> them and the animals?
> Yen Yen

The concept of family according to Ren-Li is that all of China is a family and must function in harmony. Although that philosophical concept is sometimes inconsistent with Chinese practice, Chinese families are indeed much larger, both physically and psychologically, than our western concept of family. In all of China, there exist about three hundred family names. Therefore, technically, and to a degree psychologically, in a country of over one billion people, there are only about three million different families.

Basically, there are four types of families on Taiwan. First, the extended family consisting of husband and wife, natural, adopted, and foster children; the husband's brothers and their wives and children; and husband's parents, grandparents, and all ancestors -- all bound together by land and family name. Second, the stem family, consisting of husband and wife; ancestors, natural children, and, at times, married brothers. The stem family usually has two generations in residence while the extended may well have three or more. Third, the nuclear family, consisting of husband and wife and their unmarried children. Fourth, the uterine family is a concept developed by Margery Wolf in Women and the Family in Rural Taiwan. This definition is a behavioral and psychological unit rather than an overt family unit.

And what of the family system, Ren-Li and industrialization? In 1977, Wang Wei-lin surveyed 3595 families throughout Taiwan. Of 1165 families, 25 percent were extended, 21 percent stem, and 54 percent nuclear. Of 2430 urban families sampled, 10 percent were extended, 26 percent were stem, and 64 percent nuclear. Certainly, it looks as though the trend is toward the nuclear family. But if one looks closely at the data, it seems phenomenal that in urban, industrialized Taiwan, where the economic systems are specialized and nonagricultural, 36 percent of the population still maintains the extended- or stem-family system. If Taipei, a city of over two million people, has even a five percent extended family percentage, I would see that as an incredible phenomenon and inconsistent with the views of those western sociologists who say that Taiwan will soon be westernized and the extended and stem family disappear. It is my belief that because of Ren-Li, Taiwan culture is different from western culture and Taiwan will have a somewhat different developmental pattern than western economies.

With the developing economy and the resultant changes in family structure, Ren-Li is being assaulted. Taiwan is in danger of not only becoming westernized but Americanized. I've seen movement over time of governmental entities on Taiwan using American models for human service programs. Some programs are ineffective in America; why should they work in Taiwan? That is why we are here today, to determine how to industrialize, yet hold, clear, central values.

What is the role of the elderly in the industrialized movement? I would cite the issues given by Commissioner Bai Itsiu-hsiung at the 1980 Sino-American Conference:

> As traditional filial piety, a key virtue of Confucianism, has faded, the aged population in the Republic of China has undergone a steady increase, year by year, due to economic development, better medical care, improved sanitation, and a higher level of education. New problems for the aged are emerging, including economic security, housing, health, recreation, work after retirement, and loneliness. These problems are increasingly the concern of the government, which has been developing homes for the aged, and long-life clubs for the aged in the communities. Unfortunately, so far, the Department of Social Affairs in the Ministry of Interior has not been able to devote a great deal of staff time to the aging. One division of the department has two staff to handle policy decisions, legislation, planning, supervision, implementation of women's welfare, child welfare, welfare for the aged, welfare of the handicapped, welfare of farmers, welfare of fisherman, and juvenile delinquency.

It is important and telling that only five years later, Commissioner Bai has sponsored this conference to discuss aging policies. I highly commend him for his efforts and commitment of effective research and planned programs for the elderly citizens of Taiwan.

Some central values in Chinese cultures are peace, love, justice, and harmony. But what of American values? I will now speak to the Chinese of value components common in America. One of two central backdrops for American values is Protestant Ethic -- which values money, success, activity, work, rugged individualism, and thrift. According to the precepts of the Protestant Ethic, if one is thrifty, works hard, is independent, and attempts to make his own way in the world, the person is "goodly" and, by implication, Godly.

The second central value baseline is the Judeo-Christian Ethic which espouses the value of kindness, justice, helping those less fortunate, humility, goodness, but primarily, human dignity. It is the precept of human dignity and innate self worth that is one of the supreme values of the Judeo-Christian ethic. The value of human dignity is the reason for the establishment of social welfare systems in the west and many times directly conflicts with values perpetuated through the Protestant ethic. Thus, central American values are in a constant state of conflict and change.

What has all this to do with determining a cultural baseline? It has everything to do with it. Values determine culture; they are the conscious and unconscious goals of society. They are manifested in duties, obligations, accountabilities, laws and ethics. So what is the Chinese/Western cultural baseline or "commonness"? I believe the commonness lies in the central Chinese values of *love* and *justice*, resulting in *peace* and a cornerstone value of the Judeo-Christian ethic -- human dignity. If we give people dignity and justice, love and peace will prevail.

I agree with Dr. Sheppard that human animals have more similarities than differences, but many times cultural differences get in the way. It is my hope that through our joint efforts, we can learn to overcome cultural differences and become concerned with our central values: love, kindness, and the worth of every individual--for the good of our wellbeing and of society as a whole. Talking about common human needs and developing specific mechanisms to become more united in a loving world society -- not only for us, but for our children and their children and generations to come.

# Social Services for the Elderly in Taiwan

National Association of Volunteers
Taiwan, Republic of China

"When the great principle prevails, the world is a commonwealth. Officials are selected according to their virtue and capacity; mutual trust is upheld and good neighborliness cultivated. Hence, men do not regard as parents only their own parents, nor do they treat as children only their own children. The aged are cared for until the end of their life, the able-bodied employed, the young brought up, and all widows and widowers, orphans and the childless, as well as the sick and the invalid, are looked after. Men have their respective occupations and women their homes. While it is reluctant to see resources lying idle on earth, they are nevertheless unnecessary to be kept in one's own interest; while indolence is deplored due to lack of self-effort, the latter may not be merely for personal purposes. In this way selfish schemings are repressed and robbers, thieves and other lawless elements out of existence. There is no need for people to shut their outer doors and this is called the great cosmopolitanism."

from "Cosmopolitanism," in Book of Rites by Confucius (551-479 B.C.)

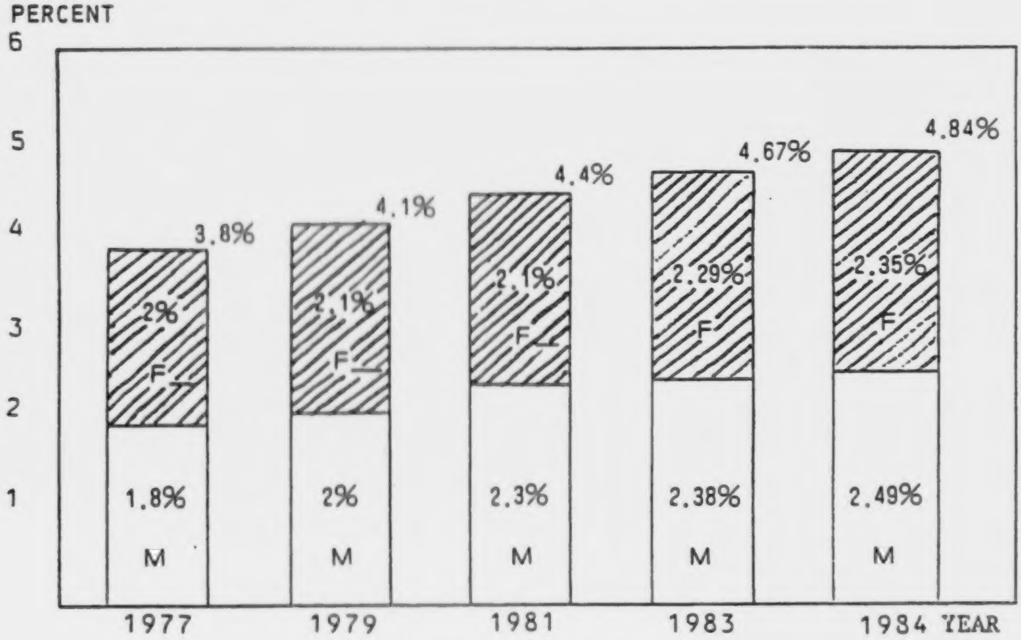
## Introduction

The development of Taiwan Area of the Republic of China is going along with the rapid economic growth and unceasing social change. The needs of the people are varied with different ages.

Through improvement of public health and implementation of population policy, the low mortality and birthrate lead aging population structure. The rapid growth of aged population accelerated the various problems of the aged. For distinctive features between rural and urban area, the problems raised in Taiwan province, Taipei and Kaohsiung City are somehow different. The provided services are characterized by meeting various needs in different areas.

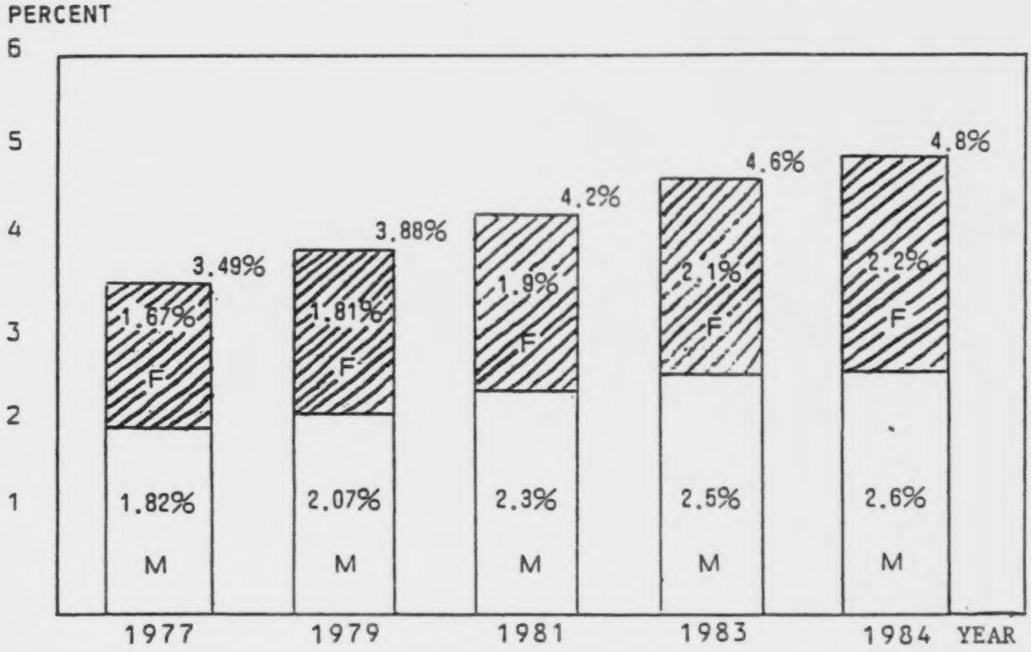
To respect the aged is a tradition in Chinese society. For decades, the agricultural society is gradually becoming an industrial one. Many good traditions and virtues are hit and shaken by the waves of modernization. The "Welfare Act for the Aged" was promulgated in 1980, and the various services for the elderly were enforced. Generally speaking, the provided services include accommodation, medical & health care, leisure activities, educational programs, homemaker service, academic studies, and volunteer service. Through providing adequate services and enhancing the traditional virtue "to take care of one's own aged parents first and then extend the same care to the aged people in general", these services aimed at attaining the social goal "the aged are cared for until the end of their life" which was advocated in "Cosmopolitanism" by Confucius.

Population of age 65 and over in total population of Taiwan Area



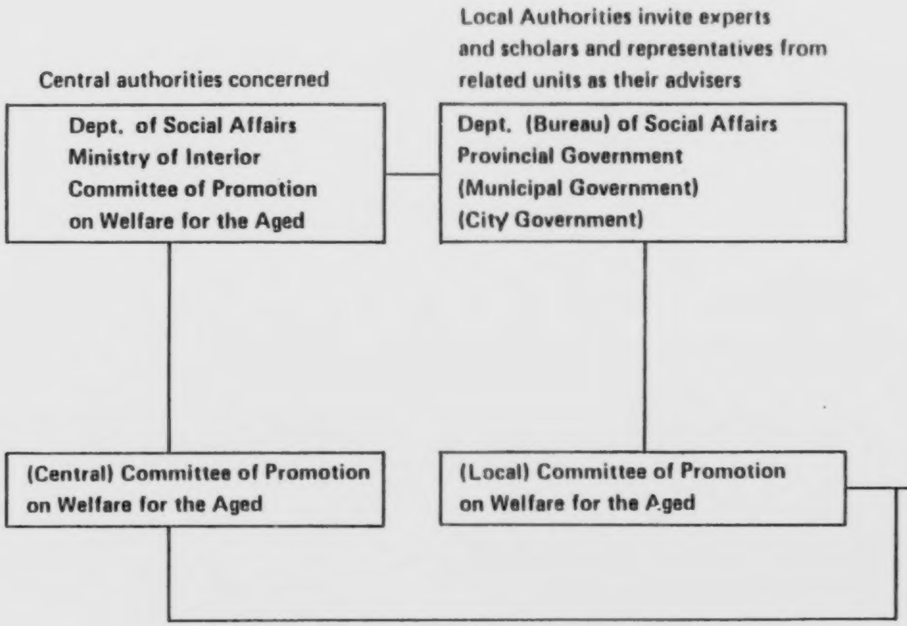
Source: Statistical Abstract of Interior of the Republic of China (1985, p. 43)

Population of age 65 and over in total population of Taipei City



Source: The Statistical Abstract of Taipei Municipality (1985, p. 73)

# ORGANIZATION AND TASK OF THE COMMITTEE OF PROMOTION ON WELFARE FOR THE AGED


Local Authorities invite experts and scholars and representatives from related units as their advisers
Central authorities concerned
Dept. of Social Affairs Ministry of Interior Committee of Promotion on Welfare for the Aged
Dept. (Bureau) of Social Affairs Provincial Government (Municipal Government) (City Government)
(Central) Committee of Promotion on Welfare for the Aged
(Local) Committee of Promotion on Welfare for the Aged

Work Contents

1. Studying, counseling, examinating and coordinating on welfare business for the aged.
2. Planning, investigating, studying and evaluating on welfare measures for the aged.
3. Coordinating the related units to implement welfare business.
4. Cultivating and training the workers on welfare business for the aged.
5. Gathering important reports concerning welfare for the aged.
6. Other work items concerning welfare for the aged.

## Providing Services to Meet the Needs of the Elderly

### A. Accommodation Agencies

#### 1. Free accommodation

It is provided to the aged who are low-income and without supporters to take care of them. At present, the public agencies and some private agencies which are entrusted by government both provide this service.

#### 2. Self-paid accommodation

There are few public agencies providing this service. For very old people who need it, government encourages private agencies to provide this service to meet the needs of the elderly.

### B. Long-term Care Agencies

It is to provide accommodation for the aged with chronic or paralysis disease. The public agencies only accommodate low-income older people who live alone. The government has entrusted some private agencies to provide this service and encourages them to extend their service to the aged without economic problems.

### C. Recreation Agencies

It aims at arranging activities on leisure, recreation and social gatherings. The Evergreen Club, Longlife Club, and regional Leisure Activity Center for the Elderly are established to provide various programs and activities for the aged.

### D. Service Agencies

It aims at providing comprehensive services. To meet the physical, psychological and social needs of the aged through setting up service units for the aged. This is a way to alleviate the adjustment problems in the industrial society.

E. Medical and Health Care Service

This service provides free physical examination and reduction of medical expenses for the aged.

F. Public Transportation

There is a 50 percent reduction on transportation fare for the aged when they take a public or private ship, bus and airplane. Free bus service is provided to those aged over 70 in Taipei, Kaohsiung and some cities of Taiwan Province to encourage the elderly taking part in more social activities.

G. Homemaker Service

Homemaker Service is provided to those low-income older persons who live alone and with functional problems. The service items include meals, cleaning, clerk, health care, and leisure arrangements. This service provides help for obvious improvements in the life of the elderly.

## Evergreen Academy

Many regional Evergreen Academies (Colleges for the Elderly) are set up in various districts in Taipei, Kaohsiung and Taiwan Province to provide educational courses and activities in order to meet the needs of the elderly. The data bank of specialties of the members was gradually set up through activities. The aged volunteers take part in various social services, thus increasing the interaction with the society and the degree of life satisfaction.

## Studying and Training to Upgrade the Quality of Service

Through inviting scholars and experts to hold pre-job and on-job training so as to make social workers recognize the characteristics and needs of the elderly and provide adequate service to them. To upgrade the life quality of the elderly, it can be reached by upgraded services and enables the elderly to enjoy their silver age.

## Implementing Services for the Elderly Through United Social Resources

Establishing welfare institutions and providing services by government are always limited by budget and staff employment. It will be more efficient in providing services for the elderly if we can make good use of the united social resources. When young volunteers participate, the social services for the elderly may alleviate the stress from the generation gap. The aged taking part in social services can help to show their wellness through social involvement and have a feeling of being needed; these will upgrade the degree of life satisfaction. The beneficiaries of volunteer services may change their conservative attitudes to positively render their services to the needy. Everyone can make his life meaningful through contributing their labor, wisdom, or experience.

## Prospects

There are three respective aspects to promoting the services for the elderly in the Taiwan Area, R. O. C.

### A. Establishing Adequate Concept

Services for the aged should be extended to all the elderly and we should give more concern to the unfortunate ones. The age of the beneficiaries of the "Welfare Act for the Aged" should be changed from 70 to 65. Qualifications and requirements of some services should be more flexible. The very old deserve more services. In addition to enforcement of existing services, the elderly should be encouraged to take part in the implementation of welfare for themselves in the future. It includes programming, planning, decision-making and execution for their own needs. Furthermore, advocating filial piety and providing welfare service can help to complement each other.

## B. Adjusting System

Amendments to the "Welfare Act for the Aged" should be actively engaged and legislation for other related acts and provisions concerning medical and health care, psychiatric problems, pension payment, housing units and lower taxes, should be initiated as soon as possible. A clearly defined welfare system is needed, such as the combination or coordination with the health department in Japan, Korea or in western countries like Britain and the U.S.A.

## C. Starting New Programs and Services

New programs and services should be provided to meet the needs including physical, psychological, and social aspects. Through well-planned programs and services, the elderly of the modern world will happily enjoy their long life instead of living a lonely life too long.

# Community Services for the Aged in Taipei

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## Introduction

Respect for the aged is considered a traditional Chinese virtue. When a young man moves toward middle age then into old age, it does not mean he has to become incapacitated. By virtue of his rich life experience and knowledge gained over the years, he is still able to give advice and guidance to the younger generation. Traditional Chinese culture always places emphasis on respecting the elderly, thus the aged achieve their high status in our society. With the changing of the social structure towards urbanization and industrialization and the prevalence of small families and the increases in the older population assistance for the aged has become a most important work for our government, especially after the promulgation of the "Welfare Act for the Aged" in 1980.

As a result of rapid economic growth, improvements in the environment and medical developments in our country, life expectancy has been raised to 72.45 years (69.9 for men and 75.08 for women). By the end of 1984, some 4.85 percent of the population were over 65 in Taiwan (4.8 percent for Taipei City).

Old people have encountered numerous difficulties in serving society and establishing the family. They should enjoy a pleasant "golden age" the promulgation of ethical and social norms. It is therefore necessary to arrange a proper, healthy and happy life for retired people, so they can pass on their wisdom to the young. The service programs will include medical care, leisure activity, home maker services, academic study, volunteer services, housing services, employment guidance and foster family etc. The objectives of these services are to achieve improvements in health, enlargement of knowledge, creation of wealth and increasing the enjoyment of old age.[1]

From my limited experiences in social work with the aged and personal contact with the aged as well as the research work on the leisure program for the aged in the community setting, I realize that the Chinese elderly do not want to live in an institution. They prefer to stay at home or in the community. According to the statistics, only 6 percent of the aging population who are above the age of 65 are living in Institutions, and 94 percent of the elderly are living in the family. Besides this fact, I want to mention several reasons why I wrote the chapter, namely, 1) the Chinese family emphasizes family-ties and the relationship with their friends and relatives so they do not like to be sent to live with strangers in an institution. 2) Chinese young people feel that if their parents are living in an institution, they will feel ashamed, because the others will think that these young people are so poor that they can not support the living expenses of their parents. Besides, they will be thought of as lacking in filial piety. 3) The Chinese elderly expect the parent-child relationship to be forever. 4) The Chinese elderly are more used to living in their homes, because many things are familiar to them such as the market, friends, transportation, food, clothing, etc. 5) The Chinese elderly want to feel the family atmosphere and it is hard to get such a kind of atmosphere in institutions because the Chinese elderly don't express their inner feelings or family problems to strangers such as social workers, working staffs and other elderly people.

I also want to explain the meaning of my topic. Maybe someone will ask me what do you mean by the word "Community"? For me, "Community" means a group of people who are living in the same community and have common needs, problems, interests, mutual interaction, consciousness and organization. They want to solve their common problems. Regarding the "Aged", I mean the people who are above the age of 65. According to the statistics, the aging population who are above 65 will reach five percent of the total population in Taiwan by the end of 1986. As for the word "Services", I mean the programs which will be fitting for the elderly in the community setting.

## I. The Problems and Needs of the Elderly in the Community

In 1984, I attended the 22nd International Social Welfare Conference in Montreal, Canada during August. At that time, I joined a small group on "Aging Problems". To my surprise, I was elected to be the chairman. This is the reason why I paid more attention to the content of our discussion. During the discussion, I realized that social services for the aged in Japan were excellent. Then I asked myself, why is the percentage of suicides among the elderly the highest in the world? Through the answers of the Japanese delegates, I discovered that the Japanese young people did not show their respect and care for the aged in the community and that family-ties were loosening. From this discovery, I felt that to strengthen the family-ties was very important both in Japan and in Taiwan. When we discussed the responsibility of caring for the elderly, western friends emphasized "Government", but the orientals, including the delegates from R.O.C., emphasized "Family". After the discussion, they all felt that the main responsibility of caring for the elderly rested with the family members and the responsibility of Government was secondary. Even when the elderly are sent to institutions, the family members should make visits to their elderly relatives. Through this discussion, I discovered the difference between East and West. I also realized that the needs of the elderly are extremely important. Therefore, upon my return, I really wanted to know the felt-needs of the elderly in Taipei City. After doing a survey with the students, we discovered seven categories of problems of the elderly. Namely, 1) Economic Problems, 2) Recreational Problems, 3) Educational Problems, 4) Medical Problems, 5) Housing Problems, 6) Psychological Problems, and 7) Employment Problems.

### 1) Economic Problems

After retirement, the elderly have no income, and they need pocket money and medical expenses but they do not have any steady monthly pension income owing to a lack of any retirement pension system except veterans and retired civil officers. Even some of them have bad habits such as gambling and drinking formed during their working years. Other factors are loneliness and poor parent-child relationships with their own children which results in little or no support money from them. There is a great need for a government controlled pension system.

### 2) Recreational Problems

After retirement, few of the elderly have any outside interests or hobbies. They have nothing to do and indeed do not know what to do all day. Some of them often feel the need of recreation, but they do not know where to go and they wish that there was a facility for the elderly. Their children are busy making a living, so they cannot be with their parents or relatives. Therefore, there is a great need for providing leisure programs for the elderly. According to the survey, most of the elderly are interested in watching television and travelling.[2]

### 3) Educational Problems

Some of the elderly want to learn new skills for use around the house or would like to return to academic studies like Chinese History, etc. Some volunteers are needed to help with these programs. More needs to be done in this area. Television should be encouraged to provide senior citizens with educational programs showing achievement in business, art, calligraphy etc., amongst retirees. Radio stations could program social education reports on health and security and teach things like handicrafts.

### 4) Medical Problems

Some elderly are weak physically and need a lot of medical care which costs a lot. We suggest cheaper or free medical care or hospitalization for the aged and also insurance for them and self-help or advice on health maintenance through the Mass Media.

### 5) Housing Problems

Some elderly have no house; some of them cannot live with their sons or daughters; some of them live alone; some facilities of housing are not suitable for the elderly. Most of the elderly in Taiwan have no inclination to live in the institution owing to family-tie's inconvenience in transportation, no sense of community life and expenses, meeting with the strangers, inconvenience in marketing, etc. But some of them cannot live with their sons or daughters owing to different concepts, behavior and attitude among them. Therefore, the elderly should find their own house. Actually, there is no apartment for the elderly in Taiwan with cheaper prices.

### 6) Psychological Problems

Some elderly feel that they are not respected by the young people in society. They feel they have lost their role and status in society. In the family, their sons and daughters are busy in making money and have no time to be with them, so they feel lonely. Sometimes they have some psychological problems such as not enough sleep, anxiety on sickness and death, stubbornness, coldness, feeling of uselessness and helplessness, bad temper, scolding, no interest in many things, guilty feelings, emotions, negative thinking, etc. Therefore, psychological counselling for the aged is needed.

### 7) Employment Problems

Some elderly are very healthy and want to get an odd job in order to live a more meaningful life after retirement. Actually, they cannot find jobs easily owing to their age and lack of job opportunities. After personal contact with the elderly, they express their will to work for several reasons such as increasing income, bodily exercise, sense of satisfaction or achievement, etc. Employment guidance for the elderly is needed.

## II. Framework on Community Services for the Aged

To fulfill the needs of the elderly, some social services should be provided: such as Foster Family, Day Care Center, Home Maker Services, Volunteer Services, Senior Citizen Center, Apartment for the Elderly, Medical Check up, Hospital for the Elderly, Old-Age Pensions, Aging Club, Employment Guidance, Aging Nutrition, Aging Recreation, Manpower Development, Aging Park, etc.

### 1. Senior Citizen Center

### A. Definition

Senior Center is the central point for the elderly in the community in order to strengthen the dignity, independence and participation of the elderly. It can provide several service programs such as education, creative arts, the development of recreation and leadership ability, employment, health, nutrition, social and other social services.

### B. Function

1) To provide fixed locations[3]: Sometimes several elderly gather together in different places such as shops, restaurants, under the tree or in a corridor. They need fixed permanent places.

2) Socialization: After retirement, the elderly do not have social activities which cause them loneliness and alienation as well as the generation gap, and shorter life. A center provides the opportunities

to attend the activities through which the elderly can offer their experience to the younger generation and get new knowledge in order to adapt to the changing situation in society.

3) Reeducation: Social security and continuing education for the elderly are highly respected by advanced countries. In Taiwan, we also encourage the elderly to participate in the social, educational, religious and academic activities in order to renew the spiritual life of the elderly through study, training and education.

4) To improve personal relationship: Because retirement, deteriorating health, good friends' death, departure of the sons and daughters, the elderly lose personal contact with others which cause the elderly loneliness, stubbornness and coldness. In the center, the elderly can find their new partners, friends, and foster the cooperation, personality and virtue, smooth relationship, personal life interest, family harmony and social harmony through activities.

## C. Role

1) It provides special needs and services for the elderly.
2) It stimulates, preserves and strengthens social awareness.
3) It strengthens personal relationships and unites the community.
4) It promotes exchanges in culture and academics.
5) It provides the information on the elderly in order to do research work.
6) It becomes the center of a service delivery system.

## D. Methods of Services

1) Direct Services: it stresses the direct services for the elderly.
2) Indirect Services: it stresses the indirect services for elderly.

3) Auxiliary Services: it stresses cooperation and evaluation.

4) Facilities Services: it stresses the provision of concrete recreation facilities.

E. Content of Services

1) Extended Services: the use of professional or volunteer workers to serve the elderly in their homes; such as

(1) Through providing the materials and technique on handicrafts.

(2) Mobile library.

(3) Home care services.

(4) Friendly visits.

(5) Meals on Wheels.

2) Centralized Services: The elderly can get a lot of things in this center, such as legal service, counselling, employment guidance, medical check up, education and recreation.

3) Volunteer (participative) Services: It uses the elderly manpower to serve others such as foster grand-parents, volunteer services done by retired elderly, accompanying elderly and service team of the elderly.

4) Special Program: It provides the special services for the elderly such as Day Care Services for the elderly, caring children, Workshop, Aging Housing and Meals Services.

F. Working Staffs: The size of the working group depends on the situation in the community, clients, space, facilities, services and capability of the workers. Working staffs can also include the poor elderly and the volunteers. It needs a Director, secretary, group worker, case worker, extended worker, program designer, volunteer and other professionals etc.

G. Process:

1) Initiation
2) Survey
3) Planning
4) Selection
5) Execution

H. Hardware Planning:

1) Reception Room
2) Activities Room
3) Library
4) Drama Room
5) Lecture Hall
6) Cafeteria
7) Athletic Room
8) Counselling Room
9) Handicrafts Room
10) Office
11) Ballgame Yard

I. Principle on Software Planning:

1) Indigenization and Internalization
2) Recreation and Creation
3) Locality and Individuality
4) Educational Purpose

5) Mutual Help

6) No Disturbance and Conflict

## 2. Homemaker Services

### A. Definition

Homemaker service is a kind of extended service which includes home services, writing services, medical services, supportive conversation, recreational activities and individual services for the elderly who are of low incomes and cannot get help from their relatives and want to live at home.

### B. Content of Services

The content of Homemaker Services includes:

1) Home Services: (1) Laundry & Sewing (2) Home Arrangement (3) Environmental Cleanliness (4) Assisting Meals (5) Buying Things
2) Care for Child: (1) Living Care (2) Academic Improvement and guidance
3) Services for the Illiterate: (1) Writing Letters for Others (2) The Services of a Scribe
4) Medical Services: (1) Care for the Sick (2) Accompanying the elderly to see the Doctor (3) Assisting the Activities on rehabilitation
5) Leisure Activities: (1) Walk outside the Home (2) Accompanying elderly to travel
6) Spiritual Support: (1) Care and Consolation (2) Releasing pent-up emotions

7) Assisting in making contact for the elderly: (1) Increasing Social Relations (2) Attending Religious Activities.

C. Methods of Services: (1) Through Professional Workers or Volunteers. (2) Through Direct or Indirect Services.

3. Day Care Center

A. Definition

The term "DAY CARE CENTER" is used for the children who are in the stage of pre-school. It tries to keep them in the center all day long, because their parents are busy making a living. Now this term is used for the elderly for the same function. It is a multiple and complete service system.

B. Content of Services

It provides them recreational & educational activities, food and counselling services, medical services, services for the handicapped and psychiatric patients.

4. Medical Services

A. Definition

The purpose of medical services is to protect the elderly from getting sick and to cure the elderly after getting illness. Usually, when the elderly get sick, they will go to the hospital. Because there are many patients in different levels including both young and old, the medical doctors cannot spend more time for the elderly. Therefore if there is a hospital for the elderly according to the proportion of the aging population in each area, it will increase the quality of medical service for the elderly. If a geriatric clinic in the hospital can be provided it would be the same as building a hospital for the aged.

### B. Content of Services

1) Geriatric Clinic: It provides special medical services for the elderly in the ordinary hospitals.

2) Geriatric Hospital: It provides various kind of treatments for the elderly from general clinic to psychiatric clinic.

3) Nursing Home: It provides services such as house-keeping, nutrition, observation, and limited medical services for those who are chronically ill patients.

4) Hospice: It serves the elderly who are seriously ill patients.

## 5. Housing Services

### A. Definition

Some elderly keep their own house and their sons and daughters leave the house. Housing Services include not only the house, but also recreational facilities.

### B. Content of Services

1) Private Home: It is a house owned or rented by an individual.

2) Retirement Home for the retired civil officers: It is a house for the retired civil officers.

3) Retirement Home for the Veterans: It is a house for the elderly who are retired soldiers.

4) Old Peoples' Homes: It is a house for the elderly who are poor.

5) Retirement Center: It is a house unit which includes room for couple or single, golf court, tennis court, card room and complete dining facilities. It is a kind of inexpensive resort.

6) Retirement Community: It is a living community which is very expensive. It includes different kinds of services such as swimming pool, golf court, tennis court, restaurant, laundry, garage, fancy

living room and other recreational, educational and medical services as well as a park etc.

7) Apartment for the elderly: It is a housing unit for the elderly who pay or rent the house.

## 6. Foster Family

### A. Definition

A foster family support the elderly economically, psychologically.

### B. Content of Services

1) Foster Grand-parent: The elderly receives the grand-son or daughter from another family and supports him or her economically and psychologically.

2) Foster Family: Family members can accept an aged person from another family and support him or her economically and psychologically.

## 7. Volunteer Services

### A. Definition

After retirement, some elderly are still healthy, so that they want to do some volunteer services such as Home Services, Caring for the Children, Services for the Illiterate, Medical Services, Conducting Recreational Activities, Giving Spiritual Support, Assisting the Contact, Writing the Letters for Others, Assisting the elderly to buy the City Bus Ticket, Finding Odd Jobs for the Elderly, Buying Daily Necessary Items, Sharing his own Precious Experiences with the Young People, Doing Some Help in the Church, School and

Family. Volunteer Services become an important role in Manpower development.

B. Content of Services

1) Volunteer Services done by others: Some elderly need help from others.

2) Volunteer Services done by elderly themselves: The elderly are healthy and can do some services for others.

8. Employment Guidance

A. Definition

Some elderly are very healthy and they want to do some jobs in order to increase their income and to live more fully alive. Employment services will help the elderly to develop them more fully and become important in manpower development.

B. Content of Services

Some elderly want to do some services such as cleaning, nursing, selling goods, night watcher, security guard, being consultant in the school or governmental agency or private enterprise company, giving lectures to the young people both in school and society. Some influencing factors such as physical condition of the elderly, family, interest, ability, working will, working hours will affect the choice of job.

## III. Implementation of Community Services for the Aged

1. Senior Citizen Center: Evergreen Cultural & Recreational Center

A. The aims of this center are:

1) To revitalize traditional ethical virtues to bring about more respect for the aged, so they can live in comfort and dignity.

2) To carry out the policy outlined in the Welfare Act for the aged so as to improve their health and living conditions.

3) Welfare for the aged is moving toward a new stage. Not only has the life expectancy of the aged been lengthened, but also the basic objective as outlined above can be achieved.

B. Two senior citizen centers are in use: To maintain mental and physical health and enrich the spiritual lives of the aged through leisure activities, preliminary plans have been drawn up to establish four senior citizen centers located in the east, west, north and south of Taipei. The activity centers in the east and west are already in use. The activity center in the south opened in July, 1986.

C. Lecture and Lessons: Lecture and lessons such as health care, hygiene, current events, amusing anecdotes etc. are frequently given to the aged to help them accept new ideas and a new outlook on life. In addition, scholars and experts are invited to discuss the positive values of human life.

D. Educational Certificates for the Aged: At this center, there are literature-history, social-economy, technique, language, science-tech, and gymnastic seminars scheduled and tutored by scholars or experts. Trainees, on completion of their year-long courses, are awarded "Educational Certificates for the Aged".

E. Grouping According to their Interests. Members are grouped in accordance with their individual interests.

F. Social Activities: Through this center's arrangements, social activities for the aged, such as golden wedding parties, birthday parties, trade and skill exhibits, sight-seeing trips, testimonial ceremonies, athletic meetings etc. are held from time to time outside the center, to maintain old people's dignity and extend their horizons.

G. Self-Help Services: This center is an organized unit in which, the office of director and supervisor are served concurrently by the chiefs of the division and sub-divisions of Social Affairs. There are four social workers in charge of professional services, such as activity planning and general consultation. There are also service workers administering general affairs, including the garden for the elderly. All activities are performed independently, with old people helping and entertaining each other, learning while teaching, and teaching while learning. In this way, old people may receive extensive assistance, the traditional virtue of respecting old people is upheld, and all may have a chance to serve society.

H. Recreational:

| Classification | Members |
|---|---|
| 1) Chinese martial arts club | 33 |
| 2) Folk dancing club | 30 |
| 3) Senior citizen talent show | 60 |
| 4) Magicians club | 25 |
| 5) Aerobics club | 20 |
| 6) The evergreen glee club | 100 |
| 7) Calligraphy & Painting club | 15 |
| 8) Tea Ceremony club | 60 |
| 9) Ping-Pong (Table Tennis) club | 30 |
| 10) Track & Field events club | 20 |
| 11) Gardening club | 70 |
| 12) Literature club | 10 |
| 13) Photography club | 31 |
| 14) Mountain climbing club | 25 |
| 15) Classical Chinese music club | 36 |
| 16) Fortune-telling club | 20 |

I. Educational

| | Classification | Members |
|---|---|---|
| 1) | Modern history class | 15 |
| 2) | Ethics class | 13 |
| 3) | Economics class | 8 |
| 4) | English conversation class | 176 |
| 5) | Elementary English class | 199 |
| 6) | Japanese conversation class | 9 |
| 7) | Mandarin class | 99 |
| 8) | Chinese brush painting class (Flowers & Birds) | 70 |
| 9) | Chinese brush painting class (Landscape) | 48 |
| 10) | Calligraphy class | 116 |
| 11) | Yoga class | 53 |
| 12) | Chinese literature class | 57 |
| 13) | Chinese opera techniques class | 30 |
| 14) | Yi-King class (Studies of the book of changes) | 30 |

2. Home Maker Services

The Bureau of Social Affairs started Home Maker Services in 1984. Some social services have been accomplished such as:

A. It hired Home Workers on Home Maker Services

They have built up 8 social service centers including Ta-An, Chung-Shan, Lung-Shan, Shuang-yuan, Sung-Shan, Nei-Hu, Ku-Ting, Ta-Tung, Yen-Ping. They hired 8 Home Workers to serve Home maker Services for the low income families. They provided home services, writing services, medical services, supportive conversation, recreational activities and individual services. According to the annual report in 1985, they have handled 122 cases from July 1985 to February 1986. Almost serve 82 cases each month. They spend more time in home services which was 40% of the Home Maker Services. Usually the Home Workers serve once a week, but sometimes they have to serve twice or three times according to the actual needs.

B. They used volunteers for friendly visits

Because the elderly were so lonely and they needed companions in order to release their inner anxiety, the Bureau sent the volunteers who have received training to pay weekly visits and talk to the elderly and accompany them to out-door activities and reading newspapers and magazines and help them to prepare meals and to see the medical doctors. For the time being, there are 14 volunteers to do these kind of services.

C. A subsidy for living equipment and necessary things

1) It used the subsidy from the Ministry of Interior for living equipment, buying gas canisters, electronic fans, tables, chairs, electronic pots, underwear, quilts etc.

2) It used donations from individuals to buy quilts, blankets, thermos bottles, radio and electronic pots.

3) It distributed the used electronics to the low income citizen.

D. It carried out the aging activities and aging clubs

The social service centers including Chung-Shan, Ta-An, Lung-Shan, Shang-Yuan, Chien-Cheng, Cheng-Chung, Nan-Kang, Sung-Shan organized various kinds of aging groups and helped them to do some meaningful activities such as sports, recreation, travelling, study on the meaning of life, fostering authenticity and self-government attitude, 382 elderly attended these activities.

E. It helped the elderly to solve their problems on such as living hardship, psychological maladjustment in order to help them to live peacefully. The social workers also helped the elderly to solve their problems in economics, social relationship housing, medical care etc.

### 3. Day Care Center

The commissioner of the Bureau of the Social Affairs in Taipei, Mr. Bai, is planning to do this.

### 4. Medical Services

In 1967, the Taipei City Government formulated a plan to provide health and medical services for old people, which emphasized health care, prevention of various illnesses pertaining to the aged, and medical treatment for the sick. People over 65 are entitled to receive care free of charge. A manual concerning medical care and knowledge was also compiled and issued to help them take care of their health, drawing up "Medical Benefits Standards for the Aged" to lower the burden for expanding the health and medical care. Those aged 70 and over are entitled to preferential medical treatment, while members of families needing social assistance are entitled to free medical treatment. Those aged 65 and over are entitled to free physical examinations and clinical care.

A nursing home will be set up especially for aged patients who are suffering from paralysis or chronic diseases. In addition, the private business sector is being encouraged to establish such homes so that welfare of the aged can be enhanced.

There are only two Geriatric Clinics in Taiwan. Namely, National Taiwan University Hospital and the other is in Taichung. There is no Geriatric Hospital in Taiwan. There is no Hospice for the elderly in Taiwan.

### 5. Housing Services

1) Small Retirement Center: A large building called the Songpo Hostel has been established to provide boarding house type

accommodation for older people who are able to provide their own expenses. Currently holding 180 people, the hostel will be enlarged to accommodate more soon, under City Government plans. Comfortable and peaceful surroundings with proper care will be provided to the residents in these facilities.

2) Old Peoples' Home: All old people without support are to be settled in the Kwang Tzu Poai Institution and How Jang Righteousness House or a private institution, the Ai-Ai Yuan. Those who require personal care but not financial assistance can at their own expense go to the Songpo Hostel, while retired government employees are taken care of at a nominal charge.

3) Retirement Home for the retired civil officers: It is planned to enlarge the Yang Ming Home for the aged to accommodate retired government employees by paying limited expenses.

There is no apartment for the elderly and retirement community in Taiwan.

### 6. Foster Family

Up to the present, there is no Foster Family and Foster Grandparent services.

### 7. Volunteer Services

Some elderly have started the volunteer services in the Senior Citizen Center and Aging Homes.

### 8. Employment Guidance

There is no Employment Guidance services for the elderly in Taiwan.

### 9. Special Privileges for the Aged

A special celebration for the aged is held during the traditional Chinese Tsung Yang Festival on September 9 of the Chinese Lunar Calendar each year. Trophies and certificates are presented to people over 70 by the City Government. The certificates can be used by old people for many welfare services and privileges, including free bus-rides and other facilities. We hold activities to praise the elderly who have made contributions to our society and have propagated the ethical virtues of filial piety.

## IV. Reflections and Suggestions

### 1. Reflections

1) Government has provided a lot of services for the elderly such as home maker services, limited medical services, housing services, limited volunteer services and special priviledges for the aged, etc. But some services for the elderly are not provided such as foster family, employment guidance, day care center, senior citizen center, etc. And some services should be strengthened such as volunteer services, medical services, housing services etc.

2) Some policies[4] on the services for the elderly provided by the Ministry of Interiors are very encouraging; such as (1) To plan and build community housing for the aged; individuals and social groups are to be encouraged to set up private social care centers for the aged. (2) The provincial and the city government are monitored to encourage ethical relationships and cooperate in the care for the lonely aged people jointly by the people living in the same community and local governments. Individuals are encouraged to construct

housing to take care of the old. Voluntary service groups are to be encouraged to render in the home services such as medical care, diet guidance, environmental hazards and health maintenance. (3) Services-Professional training for the working staff on the welfare of the aged. (4) To strengthen the establishments for the caring of the aged: including medical and convalescent organizations, as well as the founding, and guidance of the leisure centers and service groups. An integrated welfare service system should be established. (5) The provincial and City Governments are to be supervised to implement effective welfare measures for the aged in order to improve their spiritual life. Complete free health examinations should be provided for the aged. (6) Education for the aged should be initiated to increase their knowledge which, combined with their experience and wisdom could be used as a social contribution.

3. Regarding the community services for the aged, private sectors are not doing so much, but they are very interested in doing volunteer services, TV programs on social education, Radio Programs on social education, publishing some books for elderly.

3. Suggestions

1) Further efforts are still called for to strengthen welfare measures. Funds and development of specialized working staffs to march forward to the geriatric targets of the advanced countries.

2) Foster Family, Employment Guidance and Day Care Center should be started according to the availability of funds.

3) Some community services such as volunteer services, medical services, and housing services should be strengthened.

4) To encourage the private sections to participate more in this regard.

5) To encourage the young people to serve their older parents well and try their best.

6) To encourage industry to pay attention to the pension system for their workers.

7) To encourage young people to foster good hobbies, so that they will live a better, meaningful and happy life.

8) To encourage the effort from the community Board of Directors besides the efforts from the City Government.

9) Employment Guidance and Nutrition Services can be provided in the senior citizen center.

10) Aging park could be included in the Retirement Community or Retirement Center.

11) To serve the elderly in the community setting not only belongs to the responsibility of government or volunteers, but also belongs to the elderly themselves, their family members, relatives and neighbors.

12) To sponsor an elderly with certain amount of money per month would be a big step for reaching the ideal of practicing Foster Family.

## Conclusion

The problem of the aged has been a humanistic one which found expression in sympathy toward the needy and the unfortunate. Later on, it developed into a chronic social problem. It has been a development of the last twenty years. A number of countries have studied and promulgated welfare laws for the old people and set up a relevant administration framework.

Taipei City Government has done a lot for the community services for the aged; but from our reflections, we still need to do more.

Some problems which the elderly in Taipei have still exist such as poverty, sickness, loneliness, homelessness, ignorance, suicide, selfishness, stubbornness etc. Therefore, we need to work on them.

This paper can not include the situation in Taiwan Province and Kaohsiung City owing to my limitations in time and information. I hope that someone can make a more complete paper in order to give an integrated picture on community services for the aged in the Republic of China.

Because the aging problem is a new area of study in Taiwan, it is very hard to find available research reports from abroad and within the country. The function of this paper is to give you some ideas about the Community Services for the aged in Taipei. I hope the experts both from abroad and within the country can give me your advice and comments. I would be grateful to you.

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# Community Support for the Elderly:
# Factors Influencing the Contribution of the Family

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In recent years, the pattern of caring for the elderly has shifted from an emphasis on placing them in formal institutions to enabling them to remain as long as possible as members of the communities to which they belong.[1] The rationale underlying this change is obvious, though its effects have yet to be assessed. In discussing the pros and cons of enabling the elderly to remain in the community, this paper will use, as an example, the case of Hong Kong where the "care in the community" approach has been adopted for nearly 10 years and its outcomes are available for evaluation.

The following discussion will first begin with a brief account of the changing ideas in Hong Kong about the care of the elderly. Attempts will then be made to explain the circumstances leading to the adoption of the "care in the community" approach in 1973 and its subsequent development. Following that, the findings of a survey on the life-style of the elderly conducted in 1983 will be related, with the purpose of assessing the contribution of the family towards helping its elderly members to remain in the community. It is hoped that the assessment will reveal the factors affecting the family in providing this help.

## Development of Policies Regarding the Care of the Elderly

As a society with more than 98 percent of its population being Chinese, Hong Kong has a tradition of venerating the old. There is no doubt that, as a result of urbanization and industrialization, Hong Kong is now very different from what it has been 20 or 30 years ago when Confucian norms and values still prevailed; but it will be a mistake to think that the people there have become totally Westernized. The traditional idea that "the elderly are like unto a treasure at home" may no longer be entirely true, but it is also incorrect to assume that they are not shown the slightest respect in the family. What needs questioning is not whether the elderly are still considered venerable in the family and society, but what kind of changes have occurred in their image and status and how these have affected the pattern of care provided for them.

The changing ideas about how the elderly should be cared for reflects to a certain extent the changing perception of the image and status of elderly persons. In Hong Kong, until the mid-1960s, as the elderly still occupied an esteemed position in both the family and the society and were greatly respected, it was strongly believed that their care must be the responsibility of the family. In its first policy paper in 1965 on the aims of social welfare services in Hong Kong, the government stated that:

> It is of the greatest importance that social welfare services should not be organized in such a way so to gain a hold over the community, or to accelerate the breakdown of the natural or traditional sense of responsibility -- for example by encouraging

> the natural family unit to shed on to social welfare agencies, public or private, its moral responsibility to care for the aged or infirm.[3]

Given the above position, no policy was deemed necessary for social services to meet the needs of the elderly. Furthermore, since those persons aged 60 and over (defined as being old in Hong Kong) in the mid-1960s represented only 5.7 percent of the population and most of them were living with their children, one might accept the argument that the care of the elderly had yet to become an issue of high priority. However, the worry that the provision of social welfare services would accelerate the breakdown of the natural or traditional sense of responsibility was pure conjecture since social services for the elderly had not yet been provided on a large scale at a time when more and more families were already finding it difficult to take care of their elderly members. Evidence of their difficulty could be found in the increasing demand for a wide range of social services for the elderly, especially beds in homes for the aged.[4] The refusal to establish a policy on social services to meet the needs of the elderly in the mid-1960s was in fact based on the conception that since the elderly were still commanding the respect of their family members, they should therefore be supported by them.

First, the number of elderly persons had steadily increased so that in 1971 those aged 60 and over represented 7.4 percent of the total population, and it was projected that this age group would increase to approximately 10 percent in 1981.[5] Second, notwithstanding the belief that children should support their elderly parents, the nuclear family was becoming the norm rather than the exception.[6] Third, although some social services were not provided by the government specially for the elderly, more and more of the individuals using these services were members of the older age group. For example, after the introduction of a cash public assistance scheme in April 1971 to bring the income of needy individuals and families up to a basic subsistence level, it was found that nearly half of those eligible were aged 60 and over.[7] The unrest which occurred in Hong Kong in 1966 and 1967, though mainly political in nature, also convinced most people that Hong Kong was no longer the same society it used to be, and relationships between different members of the community and within the family were rapidly changing.[8]

In view of these rapid changes and the increasing plight of some old persons who lacked proper care, the government found it necessary in 1972 to set up a Working Party to look into their needs and to make appropriate recommendations on how the government might best provide for those needs. The Working Party presented its report in 1973. As well as recommending the introduction of a wide range of social services to meet the specific needs of the elderly, it suggested an approach that later became the direction for further development of services for the elderly in Hong Kong. In brief, the approach proposed concentrating on "care in the community" as the guiding principle. By this, it meant that "services should be aimed primarily at enabling the elderly to remain as long as possible as members of their family, rather than at providing the elderly with care in residential institutions outside the community to which they are accustomed."[9] The services referred to included community nursing, home help, day care, laundry and canteen services, social and recreational activities, hostel accommodation and sheltered employment. Members of the Working Party further believed that this approach "makes the best sense from the point of view of the elderly themselves, their families, and the community at large."[10]

The adoption of the "care in the community" approach implied no doubt a diversion from the previous assumption that the care of the elderly must be the sole responsibility of the family. The approach, however, retained to a great extent, the contribution of the family in taking care of their elderly members; and evidences later indicated that for the majority of old persons, the family remained in fact the most reliable source of help and support.[11] What the Working Party had actually achieved was thus a concession that public or community social services were needed to assist the elderly who either had no family in Hong Kong or their family members were unable to shoulder fully the responsibility of providing them with care. But while the Working Party accepted the importance of community social services, it failed to distinguish their roles from that of the family and to identify clearly the parts that each should play in supporting the elderly. It is obvious that in recommending the "care in the community" approach, the Working Party had concentrated on its merits over residential care, while assuming that so long as some care was provided for the elderly, either by their own families or the community at large, they should be content in the environment they knew. It had not bothered therefore to look into the factors which would make the approach a success, the possible difficulties it might encounter, or the dynamics ensuing from the different roles assumed by the family and the community in supporting the aged.

No doubt, as a concept, the "care in the community" approach has its attractions and is most suitable for developing countries which, on the one hand, can ill afford the expensive cost of institutional care for the elderly, and on the other, must rely in reality on the family to provide the major portion of care. So, the only change that was really ushered in by the introduction of the "care of the community" approach was the recognition that the family needed help in caring for its elderly members and it was not a shame to ask for assistance. In other words, the approach introduced a new idea that the care of the elderly was a joint effort of the family and the community. This was new because traditionally the care of the elderly was regarded in Hong Kong, and perhaps in most developing countries, as entirely the family's responsibility so that anyone who needed outside support would be considered cursed.[12]

After the publication of the Working Party's report, the "care in the community" approach quickly gained the support of the public in Hong Kong. The government then incorporated the idea in a policy paper on the future development of social services for the elderly in 1977, and introduced a whole range of community social services for the elderly.[13] However, despite the government's effort to provide the necessary services, it seems impossible to satisfy the needs as demonstrated by the long waiting lists for nearly all social services for the elderly.[14] The lack of community social services to meet the needs of the elderly is, of course, not particular to Hong Kong. As Little once pointed out, "while lip-service is given to the value of community living for the elderly, home-delivered services to supplement family care are in most countries seriously deficient."[15]

Subsequently, studies conducted on the needs of the elderly found that community social services available in Hong Kong were, instead of serving the entire elderly population, usually taken up by the lonely elderly who, in the former days, would have been admitted into residential institutions.[16] In other words, the "care in the community" approach has succeeded in reducing the pressure on residential institutional services for the elderly, rather than relieving the burden of the families in taking care of their elderly members. To put it in simpler terms, the provision of community social services in Hong Kong has given a substantial number of elderly persons, who lack the help of family members, the opportunity of staying in their own communities instead of admission into residential institutions. For the majority of the aged population, their care remains nevertheless largely a family affair. Given this situation, the questions that need to be asked at this point are: How well are families fulfilling this responsibility? What factors would be influential in encouraging families to take up the responsibility? The following relates a study conducted by the author in an attempt to answer these questions.

## Factors Influencing Family Care for the Elderly

Realizing the continuing importance of the family in the care of its elderly members, a study was conducted by the author in 1983 to look into the life-style of the elderly, particularly their relationship with their family members.[17] The study took the form of a survey and one of the assumptions was that the elderly would have a greater chance of receiving assistance from other family members if they succeeded in maintaining a harmonious relationship with them. The survey successfully interviewed 441 elderly persons from a sample randomly selected from among households having at least one person aged 60 years or above and a total household income of below HK$3,500 a month.[18] The HK$3,500 household income level was chosen because it was thought that the poorer half of the households in Hong Kong would have greater need for assistance of their families. Though the number of elderly persons interviewed appeared small, comparisions with the characteristics of the general elderly population indicated that they formed a representative sample.

To find out the association between the possibility for the elderly to receive assistance from their family members and the kind of relationship maintained between them, those in the family responsible for taking care of the elderly were asked two questions. The first question asked them to describe their relationship with the elderly and the second inquired whether or not they had been regularly giving money to the elderly. The second question was asked because monetary assistance was perceived as a most obvious sign of the readiness of family members to render help to the elderly. And in Hong Kong, even today, it is still an obligation for children who have come out to work to regularly give money to their parents as an expression of their respect, though the latter may not have the need for it. Findings of the survey are shown in Table 1.

Table 1

Nature of Relationship by Whether Giving Money or Not

| | Regularly giving money to the elderly respondent? | |
|---|---|---|
| Nature of Relationship | YES<br>% | NO<br>% |
| Very good to good | 72.9 | 60.9 |
| Fair to Unsatisfactory | 27.1 | 39.1 |
| Total Number | 192 (100.0) | 161 (100.0) |

Gamma= .26760
Note: Only 353 family members gave answers to the question.

Answers indicated that those who gave money to the elderly tended to have better relationships with them than those who did not. A preliminary conclusion that one may draw from this is that a harmonious relationship induces greater readiness among family members to help the elderly. To further examine what factors would be most influential in shaping this relationship, other questions asked in the survey were examined. Since the elderly in Chinese societies were believed to be held in high esteem in their families, an attempt was made to correlate their status in the family with the kind of relationship they maintained with family members. However, as indicated in Table 2, the elderly usually thought very lowly of themselves and more than two-thirds agreed with the statement that they were only waiting for death to come. Obviously, this low image that the elderly had about themselves could hardly make them feel important in the family. Other findings of the survey also indicated that the elderly were no longer holding a prestigious position in the family or the society. When asked for their opinion on the general attitude of the Hong Kong public towards the elderly, only 55 percent of the family members described it as respectful while 36.5 percent held the view that people in Hong Kong either ignored or showed disrespect towards them.[19] Studies conducted by other researchers on the attitude of the public towards the elderly further confirmed that the elderly were seldom consulted on important family matters.[20] Thus, at least for the poorer half of the households in Hong Kong, it seemed obvious that the elderly could no longer command so much respect that others in the family felt it obligatory to support them.

Table 2

Self-Image of the Elderly Respondents

| Item | Strongly Agree | Agree | No Opinion | Disagree | Strongly Disagree |
|---|---|---|---|---|---|
| Less useful as one grew old | 35.0 | 49.0 | 1.0 | 10.0 | 5.0 |
| Felt isolated | 7.0 | 44.0 | 2.0 | 38.0 | 9.0 |
| Waiting for death to come | 23.0 | 43.0 | 2.0 | 23.0 | 8.0 |

*Answers in %

On the other hand, the survey revealed that other factors seemed to have exerted a greater influence on the relationship. An example, as shown in Table 3, was whether or not the elderly were able to regularly render assistance in household chores. This might be a special feature of low income families in that with both couples going out to work, the elderly were treasured for their help in looking

70

after the house or taking care of the young children. It would not be too difficult to understand that elderly persons who could render such help would be better able to maintain a harmonious relationship with their family members.

Table 3

Nature of Relationship by Whether Assisting in Household Chores or Not

| | Elderly respondent assisting in household chores | | |
|---|---|---|---|
| | No | Frequently | Totally dependent on the aged |
| Nature of Relationship | % | % | % |
| Very good to good | 60.4 | 76.9 | 78.8 |
| Fair to Unsatisfactory | 39.6 | 23.1 | 21.3 |
| Total Number | 212 (100.0) | 104 (100.0) | 52 (100.0) |

Gamma= -.57243

It may not be possible to delineate from the findings of a single study all the factors influencing family support for the elderly. But the above analysis clearly suggests that although Hong Kong is mainly a Chinese society, it can no longer count on the traditional esteemed position of the elderly in the family to encourage support for old persons. It has now become a fact that the elderly in Hong Kong are no longer venerated as they were in the past and their low image of themselves may even have a negative effect on their relationship with other family members. It is not the intention of this paper to examine all the relevant factors which would induce a harmonious relationship between the elderly and those living with them in the family, but findings of the present survey seem to suggest that rather than some of the traditional ones, like respecting the old, other more practical factors, like whether or not the elderly are helping in household chores, may now have a greater influence.

## Conclusion

This paper begins with a discussion of the different patterns of support for the elderly. It is argued that even in societies like Hong Kong, where the traditional value emphasizes the responsibility of the family in taking care of their elderly members, people have found it necessary to adopt an approach which aims at combining the efforts of the family and the community-at-large in providing the necessary help for the elderly. The approach is known as "care in the community" and its objective is to enable the elderly to remain as long as possible as members of the communities to which they belong.

A closer examination of the "care in the community" approach reveals, nevertheless, that though conceptually very attractive, it also has its limitations. So far as Hong Kong is concerned, it is found that necessary community social services are often lagging behind the needs and consequently have to be confined to those deprived of other sources of help, and in most cases this means the lonely elderly. Whilst the approach has succeeded in enabling many of the lonely elderly to remain in the community, it has not given families which have elderly members to take care of the assistance it has promised. It is not surprising that the "care in the community"

72

approach is often viewed in Hong Kong as a camouflage for "care in the family", meaning that most families are in reality continually shouldering the sole responsibility of caring for the elderly. An explanation for this insufficient service provision is that resources required to enable the elderly to remain in the community have been underestimated. The approach can thus only be seen as a better alternative to residential institutional care, and it would be a long way before the ideal of combined family and community support for the elderly could be achieved.

It is the original thinking that with the adoption of the "care in the community" approach, families in Hong Kong which have elderly members will be partly relieved of their burden in caring for them. If that does not really happen and the majority of the families are still left with the sole responsibility of caring for their elderly members, ways and means of enhancing the functioning of the family in this respect will be most desirable. Findings of a survey related by this paper reveal that family support for the elderly in Hong Kong can no longer be based on the traditional notion that the elderly are holding esteemed positions in their families. Instead, there are other factors that seem to be more influential in affecting the relationship between the elderly and other family members and thus the likelihood that the elderly are able to receive help from the latter.

What is argued in this paper is that the concept of community support for the elderly is in fact based on a number of assumptions which are yet to be proved. While the concept may present itself as a viable alternative to residential institutional care, it would be a long time before it can supplement the function of the family in caring for its elderly members, and thus produce an enhancing effect.

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# The Aged Person's Perspective

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Florida has the oldest population of any State in the nation. By the year 1900, it is anticipated that 20 percent of Florida's population -- 2.4 million persons -- will be 65 years of age or older. This large proportion of elderly has a significant impact on the economic and governmental life of Florida. The State must consider not only how to provide for the needs of the current aged population, but also must anticipate the future needs of an ever-increasing number of aged residents.

As persons age, they become more likely to come into contact with governmental programs designed to serve the economic, social and health needs of the elderly. In spite of the current argument that government should become less involved in providing care to its citizens, a study by Sheppard and Kosberg (1985) found that the public, in fact, did not support this belief in terms of care for the elderly. This study analyzed unpublished tables from the 1981 National Council on Aging survey which gathered data from 3,427 persons aged 18 and older. In investigating the extent to which the public believed the government should assume responsibility for the elderly, it was found that a majority of the sample -- 54 percent -- believed the government should assume more responsibility than it currently is in providing care for the aged.

The provision of services through governmental auspices has a direct impact on the aged person and his/her family. This report focuses on the effects of Federal and State programs on the elderly themselves. Do governmental programs enhance independence for the aged, or rather do these programs encourage dependence through mechanisms such as eligibility criteria, licensing restrictions and type and amount of services made available?

Older people in need of services are often confronted with a confusing array of programs, each with its own set of rules and regulations. The lack of coordination between and among governmentally funded programs makes it difficult for the older person to negotiate the system to get needed services. In looking at Federal and State programs, it is clear that one of the major problems is the lack of uniform eligibility requirements across programs. Each program has its own set of eligibility criteria which must be met. Some programs require income eligibility to receive home services, while other programs which offer the same services do not consider income but instead base need on functional impairment. One Federal meal program cannot, by law, limit services on the basis of income -- in fact income information cannot be requested -- while some state meal programs must assess a fee for meals if a person's income is above a certain limit. Inclusion in one government sponsored program may make an older person ineligible for other services. For example, older people residing in government sponsored housing cannot receive community based home services, since it is assumed that if such services are needed the older person is too frail to be in the housing project (Multidisciplinary Center on Gerontology, 1986).

The lack of coordination among government programs has led to administrative practices which have an impact on the elderly. As there is no common set of eligibility criteria, there is likewise no common data collection and client tracking system. Each program has its own planning, needs assessment, budgeting, accounting and evaluation system. These systems are shaped by the requirements of the State and Federal programs that fund specific services, rather than by local providers of service. In some cases, separately funded programs within the same agency must have separate systems. For the older person this means that to obtain services from different programs, he/she must complete a separate application with a separate needs assessment for each program. The older person may also have multiple service providers, each with their own follow-up forms and evaluation instruments (Multidisciplinary Center on Gerontology, 1986).

This lack of uniform eligibility criteria, data collection and administrative procedures effectively leads to greater dependence on others for many older people. The service system has become so complex and in some ways so fragmented that a new service has arisen to help the elderly -- case management. One of the aims of case management is to help older people gain the services they need from all available programs and to coordinate all of these services for the benefit of the client. Without case management it is often impossible for the older person, on his/her own, to obtain needed services.

In addition to the lack of uniform criteria leading to less independence in the elderly, the specific criteria for eligibility and evaluation of program success also has encouraged the notion that dependence comes with age. Most programs for the elderly are illness-oriented; in order to receive services one must often have evidence of a mental, physical and/or social impairment. For a program to be successful, the older person must "get better". Few governmentally sponsored programs are prevention and wellness oriented. Thus in the minds of the general public, and in the minds of the elderly themselves, there is encouraged the belief that increasing age automatically brings with it increased illness and dependence.

While most older people are in good physical and mental health, a small but significant proportion of the population -- the frail elderly -- do require some care. The responsibility for care of the frail elderly is often taken on by the family, which is defined to include all significant others. The degree to which Federal and State programs support the family in providing the needed care for the aged is somewhat unclear at this time since little evaluation of this aspect of care has been done. However, some data do exist on selected programs.

One type of program that has been evaluated is typified by the Home Care for the Elderly Program in Florida. In essence, caretakers of frail elderly persons who are in need of institutional care receive subsidy payments to provide basic support and maintenance of elderly under their care. The subsidy includes costs for housing, food, clothing and medical support services. An evaluation of Florida's program indicated that the program accomplished its goal of diverting recipients from nursing home placement and that caregivers believed that without the program they could not provide the care needed. One service needed greatly by caregivers in this program which was not widely available was respite care, particularly for elderly caregivers. The program has been successful in accomplishing its goal of supporting caregivers, but attention must be given to providing relief so as not to exhaust caregivers to the point where institutionalization of the aged client is the only alternative. Programs must take into account not only the financial aspects of care, but also the total family system if they are to be successful in meeting the needs of the elderly and their families.

The effects of caregiving were also investigated in a study of Florida's Community Care for the Elderly Program (Office of Management Review-Evaluation, 1986). This evaluation of the program, which provides home and community based services to functionally impaired elderly 60 years of age and above, was interested in a number of areas including the impact of services on family caregiving. Groups of caregivers, pre and post-service delivery, were compared. It was found that there was no significant difference in the amount of care provided (53.03 hours per week) by these two groups. These findings suggest that the provision of such services do not erode or supplant caregiving effort. Further, it was discovered that the provision of such services reduced caregiver stress. Those factors which predicted higher levels of stress were greater impairment of clients for whom care was provided, closer relationship to client (e.g., spouse or children), spending more hours on care, being in poor health and being relatively younger than other caregivers and thus feeling the restrictions on free time more acutely. It appears, therefore, that while further evaluation is needed on a national scale, the provision of home and community based services does have a positive impact on caregivers.

In summary, Federal and State government programs encourage independence in the elderly by providing a wide array of services which enable older persons to remain in the least restrictive setting possible. On the other hand, the uncoordinated system of care created by the programs serving the elderly help encourage dependence by making it difficult for the aged to negotiate the system to receive needed services. In program planning, it is essential to consider the impact on older persons of all aspects of the program, direct services as well as administrative rules and regulations, if the elderly are to be well served.

Likewise, the total family system of the older person must be taken into account when establishing programs. Services to the elderly need not erode the care provided by families, however, the social and emotional needs of caregivers must be met if they are to continue providing help to their elderly. It is critical that the government establish programs that support caregivers as they try to uphold the traditional family value of caring for the aged.

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# The Provision of Social Services in the United States[*]

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The purpose of this chapter is to present an overview of the delivery of social service to the elderly in the United States in such a way as to suggest a coherent model for such service delivery. At the same time, I will present a number of issues with which the service delivery enterprise is confronted. I hope, further, that the suggestion of the model and the issues will provoke discussion among the conference participants, with the hope that we will learn from each other. To quote my colleague, Walter Beattie, "Throughout the different countries under this rubric. Although they have many commonalities, there is much variation in the goals, organization and content of social services to the aging throughout the world."[1]

Let us see if we can reach agreement as to what we mean by the term "social services". Beattie has offered one definition as follows: "Social services are...organized societal approaches to the amelioration or eradication of those conditions which are viewed at any historical point of time as unacceptable and for which knowledge and skill can be applied to make them more acceptable. Such services therefore, are based upon scientific knowledge and humanistic values out of which are defined the roles, responsibilities, and acceptable conditions for the individual, family, community, and society." A close examination of Beattie's definition leads us directly to the conceptual base for establishing a model of service delivery. Note, for example, that Beattie inserted the phrase, "at any historical point of time", suggesting that conditions which might be considered unacceptable today might not have been considered unacceptable a generation or more ago and, further, that which is considered unacceptable today may to some future generation be considered irrelevant. At the same time, completely unanticipated circumstances of the elderly in a future generation might not even be known to us today.

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[*] This chapter was written originally for the purpose of stimulating discussion and debate about the issues raised, rather than as an original contribution to the body of knowledge and thought in the area. The chapter, therefore, relies more heavily on the ideas of others than would otherwise be expected. I am especially indebted to those gerontologists whose work is cited herein for their contributions to the debate.

Another aspect of Beattie's definition, which is worthy of our notice, is his assertion that social services are based upon both scientific knowledge and humanistic values. In other words, it will be the values of our society which will determine those problematic conditions of the elderly to which we should attend, and it will be scientific knowledge which will inform us as to how to construct and to deliver services to meet those problematic conditions. We can know little about the way in which our society's values will change in a generation or two, but we may be confident that with continued support from our governments and our institutions of higher learning, our scientific knowledge, relevant to the solution of social problems of the elderly, will continue to increase.

The cultural values pertaining to the elderly might, in some instances, be basically the same from culture to culture, but in other instances they will vary across cultures or national boundaries, depending on a wide variety of historical circumstances that I am certainly not equipped to discuss at the present time. However, in my own country, I believe we can identify some of those cultural values that influence the manner in which services to meet the perceived needs of the elderly are constructed. For example, we point to what some[2] have referred to as *faith in progress and in social change*. In such circumstances where progress and change are highly valued, the opinions, the accumulated wisdom and indeed even the potential productivity residing with the elderly may be devalued and discounted.

Another dominant value in our society has to do with the *importance of continued productivity and work*. Clearly, such value influences attitudes and policies regarding the concepts of work, retirement and the use of leisure time. Just one more example, although there are certainly many others: In American society great emphasis is placed on the *achievement of and maintenance of independence*. As the child matures through adolescence and young adulthood, the achievement of independence is applauded. To a great extent, however, the ability to maintain independence during the later years, when physical circumstances would dictate a return to a more dependent state, is also admired and valued. The importance of understanding the place of social or cultural values with respect to the development of a system of social service delivery has to do with the manner in which those values determine how society perceives the needs.

An early conceptual model of services for older persons was proposed by Beattie.[2] In that model he specified five levels of services for the aging as related to the specific circumstances and conditions of the older person. Those levels he labeled:

a) basic services
b) adjustment and integrative services
c) supportive services
d) congregate and shelter care services
e) protective services

In regard to the first level, *basic services*, Beattie meant to include services that address the needs of *all* persons, including but not limited to the aged. He included community health services, financial assistance, recreation and so forth. His second level, referred to as *adjustment and integrative services*, had as its specific goal permitting older persons to participate in the life of the community, to utilize his or her capacities and potentials in socially approved ways and to adjust to new social roles in the family and the community at large. Included, then, at this level of service would be old-age assistance, recreation services for the aging, retirement preparation (preretirement counseling) and other specialized social work services for the older person and/or his or her family. The level of *supportive services* would have as its specific goal the provision of aid to the older person, in order that he or she could remain in a familiar habitat, retaining the usual living arrangement when this is no longer possible through his or her own efforts. Services for people at this level who would include aged or handicapped persons living alone, for example, will include friendly visiting, homemaker service, motor service, provision of meals and home care. The fourth level, congregate and shelter care, would have as its goal the provision of service to protect the older person from hazards of living in the community in those circumstances where the individual, due to physical or mental infirmity, is unable to cope with an independent or family living situation. Such services would be day care for older persons, homes for the aged, housing for the elderly, in-patient medical care and substitute family care. Finally, the protective services level, according to Beattie, would have the goal of protecting the civil rights and personal welfare of older persons from neglect and exploitation by friends or relatives, and would involve the coordination of legal, medical and social services. What I have described is an early attempt at developing a model of care, and I have described it deliberately very briefly, without much of the detail that its original author had provided.

Beattie's classification of levels of service is related to specific conditions of older persons. In other words, it is a classification based on level of need. Subsequently, almost twenty years after Professor Beattie's statement, Professors Tobin and Toseland[3] proposed a somewhat more sophisticated classification of services, which considers not only level of need, which they referred to as degree of impairment, but also considered the location of the service. Imagine, if you will, a chart with three rows and three columns. The rows, representing degree of impairment are labeled 1) minimal, 2) moderate and 3) severe. The columns are labeled 1) community based service, 2) home based service and 3) congregate residential and institutional based service. It is possible, then, to name at the intersection of each row and each column a set of services provided to the elderly. For example, at the intersection of moderate impairment and community based care we would find community mental health centers among those services listed, whereas for example, at the intersection minimal degree of impairment and home based services we would find home-repair services among those services listed. It is not my intention to reproduce the entire chart provided by Professors Tobin and Toseland, but only to describe briefly the manner in which they elaborated upon a simple classification of services, based solely on need.

In describing such a classificatory scheme, however, it should be clear that I have omitted a critical issue that further discussions might very well address. That is the specific issue or goal of integrating services. As described in my discussion up to this point, it would appear that I have been talking about the provision of discrete single services, without attending to the matter of how, through governmental policy, efficiency and effectiveness are achieved by the integration of, or coordination of, a set of services which may be needed by the older person.

A second fundamental issue is related to the cultural or social values to which I referred earlier in this paper. Specifically, the question is, is it the responsibility of the central government (whether that be national government, or a regional or local governmental jurisdiction) or is it the responsibility of the individual, and his or her family or perhaps some non-governmental agent, to provide the service? A third issue is one which is the basis for a current debate among gerontologists in the United States.

The resolution of this issue, it seems to me, will be critical for the development of what Tobin and Toseland referred to as a comprehensive model for service delivery. That issue has to do with the determination of eligibility for the receipt of service: Should the criterion be need or chronological age? A number of prominent gerontologists have argued for an age-irrelevant society, in which chronological age becomes extraneous. To quote Tobin and Toseland again, "determining eligibility by need rather than by age, however, does not resolve two other kinds of questions. Should personal assets also be used, such as a means test, in determining eligibility? And, independent of eligibility considerations, do the special needs of the elderly dictate special kinds of service systems"?[3] Another prominent gerontologist, Lou Glasse, formerly the director of the New York Office for the Aging, has presented a well balanced discussion of the needed versus age debate. She concludes her argument in favor of age-categorical service provisions as follows: "The problem of equal and adequate access to services is the central issue facing aging services planners. History and experience show us unequivocally that unless government recognizes the particular vulnerabilities of any population at risk, and intervenes on its behalf, that population suffers. Age -- irrelevant programming is the free market principle applied to social services delivery. The older population in greatest need is simply not equipped at this time to survive in such a marketplace."[4] I repeat, it is not my intention to resolve the age versus need debate here. It is my hope however, that this issue, as well as the others that I have pointed to, can be discussed further and that we will all learn from each other, from our varied experiences, both personal and cultural, and that the process of developing further models of social services delivery will become better informed.

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## The Changing Aging Population: Implications For Social Services

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The size of the elderly population in the United States is expected to increase between now and the year 2000, and even more dramatic growth is likely among the very old. For example, in the state of Pennsylvania, which has the fourth largest elderly population in the United States, the population over age 65 is projected to increase by about 20 percent between 1980 and the end of the century, and a 123 percent increase in the number of persons over age 85 is anticipated. This dramatic population growth among the very old, which will be accompanied by a decline in the availability of traditional caretakers for the elderly, has important implications for aging social service delivery in the United States.

The elderly over age 85 typically have need for long-term care services. As a result of chronic illness and disabilities, they often need help with household chores and help to carry out normal daily activities such as bathing and feeding, etc. In the United States, families currently provide most of the long-term care for this group when care is provided at home. Families most often either provide care directly or purchase in-home care with private resources. The majority of public funding goes to support care in nursing homes, even though the elderly prefer to be cared for in their own homes, and nursing home care is very costly. In a state like Pennsylvania, for example, which has invested considerable state tax dollars to expand the availability of community long-term care services, 82 percent of the federal and state dollars which are annually spent for long-term care go to support care in nursing homes. In the past, the very frail elderly in need of personal care have not always been served in community services, even when public funding has been expanded to increase care for this group.

In the United States between now and the turn of the century, several changes in the current long-term care service system will likely be needed if aging services are to meet the needs of tomorrow's elderly. These changes, which are briefly outlined below, may be unique to the United States because of its methods of financing and allocating services for the elderly, the changing role of women in the United States, and the separation which traditionally has existed between medical and social services in the United States. There may, however, be some parallels for other nations to consider.

First, a better balance between community and institutional long-term care services will need to be developed. This improved balance may be achieved in a variety of ways, including changes in the ways services are currently allocated coupled with changes in the way in which they are subsidized. Some states in the United States, for example, are providing comprehensive health and social assessments for individuals referred for nursing home care, and they are beginning to subsidize services based on functional impairment levels. Some states are also experimenting with providing intensive community services as alternatives to nursing home care. In Pennsylvania, for example, we currently have underway a Long-Term Care Assessment and Management Program (LAMP) which provides comprehensive medical and social assessments for anyone, regardless of age, who is referred for nursing home placement. For those who would qualify for nursing home care, intensive community services can be offered as an alternative or to delay placement in a nursing home.

Aging service practices may need to be revised to better serve the needs of the frail elderly. Appropriate response to the needs of this group often requires an interdisciplinary approach to care. Currently, however, interdisciplinary care is not typically available through aging social services networks in the United States. Aging service personnel may need additional training opportunities in order to serve more impaired clients in community services and to participate effectively on interdisciplinary teams. Service agency practices may need to emphasize more emergency, after-hour, and weekend care. Because the very frail elderly are more impaired and more vulnerable than those who have traditionally been served, quality assurance techniques will be of increased importance to agency practice. Service providers may need to begin to take on new roles and service responsibilities as they attempt to respond to changing population needs. For example, in Pennsylvania as part of the state's community long-term care service demonstration, in one community, a nursing home is responsible for arranging community services as alternatives to nursing home care.

Families currently provide the majority of long-term care in the community, often with only minimal help from services agencies. As a result, families exhaust considerable financial resources and personal energy in attempting to provide care; but at times, the ways in which they provide care are highly inefficient and inappropriate. There is also a tendency, at times, for service providers to completely replace families, friends and neighbors who are willing and able to provide care. In order to respond to the changing needs of the elderly, aging service professionals will need to find ways to better blend formal and informal services in client service plans and provide *support for family caretakers*. New perspectives on service provision may be needed to accomplish this goal. Rather than simply providing services, service agencies may need to begin to advise elderly individuals and their families on how best to invest private resources to purchase long-term care. The elderly in the United States today have more after taxes per capita income than households overall. These resources are used at times to purchase long-term care, however, family purchase of long-term care is not always appropriate or necessary. Social service agencies may need to become long-term care investment advisors and services brokers in order to assist families in the years ahead.

Finally, *research and evaluation* will be needed to identify when and how best to intervene to better meet the needs of tomorrows elderly population.

# The Challenge of Demographic Trends to Family Support Systems for the Elderly

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Population aging is an inevitable consequence of the population transition. The shorter a population takes to reach its final stage of transition, the faster it ages. In the earlier stage of the transition, the growth rate is increasing due to declining mortality and unchanged high level of fertility, and therefore the expectation of life is increasing, so that the influences tend to counterbalance one another. In the later stage of the transition, the growth rate is decreasing due to low fertility and the length of life is increasing further, so that the influences are mutually reinforcing. This is the basic reason for the rapid increase in the proportion of the population aged 65 and over.

While emotional ties and mutual support among family members remain strong in the later stage of population transition, it is clear that demographic change will increasingly affect the capacity of the family to continue its care-giving role. The most salient is the reduction in the fertility rate and the resulting decrease in the number of children available in a family to care for aging parents. The fall in the fertility rate seems already to have peaked in both U.S. and Taiwan, and is now beginning to accelerate in many developing countries. By the twenty-first century, it will become common for many elderly persons to have few or even no children to care for them in old age.

A second factor is the increase in numbers of the extreme aged due to improvement in life expectancy. These people may require intensive nursing and other support. While family members may wish to continue care for very elderly relatives, they will in most cases lack the skill and physical capacity to provide continuous nursing supervision. Linked to the growing prevalence of the extreme aged is the increasing probability of families encompassing four to five generations. It is no longer unusual for a 40 to 50-year old person to have a 60 to 70-year old parent and an 80 to 90-year old grandparent, in addition to adult children and even grandchildren. It becomes exceedingly difficult, if not impossible, for a middle-aged person to care for two generations of elderly relatives, in addition to carrying out the roles of parent and grandparent.

The preponderance of widowed women among the elderly is another factor affecting the availability of family support. The tendency of men to marry women several years younger than themselves and the longer life expectancy of women in many areas implys that older women have a high probability of experiencing a long period of widowhood in later life. The loss of a spouse means loss of socio-economic support and companionship and makes older women vulnerable to poverty and social isolation.

Out-migration of the young from rural areas also acts to weaken the family support base available to elderly persons left behind. As fertility rates begin to drop in rural as well as urban areas, the problem of over-concentration of elderly persons, lacking socio-economic support from younger family members, will become even more acute.

In order to encounter these demographic trends which challenge the family support system for the elderly, there is a need to extend the concept of a familial network support system to kindship since the household-based family does not encompass the whole of one's kin. Defined as ties between people related by blood or marriage but not necessarily bound by a common household or place of residence, kinship network encompasses the members of both families and households, and extends beyong these to more distant, widely dispersed relations. Especially at a time when the proportion of people in the oldest age groups is increasing rapidly, when the association of impairment with advanced years is well established, and when persons in the upper ages are increasingly likely to reside in nuclear households, the capacity of kinship networks to provide needed social support to their aging members is becoming a matter of doubt and an issue of major social significance. Therefore, there is a need to conceptualize the family and family membership in terms of networks, that is, using a definition that goes beyond the classic standard concept of "residential unit". A compelling reason for this is the need to determine existing, private support systems available to Taiwan's elderly prior to developing public policy, and estimating or earmarking the resources required for health and housing facilities, nursing and other care for aging populations.

Demographic approaches to the study of kinship have been of two main types: (a) simulation research using models to establish the parameteres of size and composition of family units under various demographic conditions and (b) empirical research using census and survey data to describe the present situation of families, households and kin groups, and to forecast what may happen in the future. The major aim of simulation approach is to study the demographic factors that directly determine the size and characteristics of family units, in order to demonstrate what would be the consequences for different kin relationships of various kinds of demographic changes.

An illustration of both the central focus of family demography on the availability of kin and the importance of the demographic perspectives to issues related to family support in later life is provided by Tu's (1985) model for estimating the frequencies of kin from a high fertility/high mortality to a low fertility/low mortality population in Taiwan by applying stable population. Tu indicates that a large reduction in fertility results in large decreases in the numbers of daughters, sisters, nieces, aunts and cousins who are ever born. Reduction in death rates both increase the number of kin ever born (particularly of nieces and cousins) and raise the chances that each of these types of kin will be alive at a specified age of the reference person. There is a substantial reduction in the numbers of living descendants and collateral kin throughout the life cycle of the reference persons. Changes in fertility and mortality obviously have no effect on the number of parents, grandparents, and great-grandparents who have ever been born. Declines in mortality, however, can greatly increase the survivorship of these kin. Hence, the net effect of Taiwan's demographic transition is a reduction in the proportion of the family consisting of collateral kin -- e.g., sisters and cousins - and an increase in the proportion composed of parents, grandparents, and great-grandparents. The potential social, psychological and economic implications of changing kinship structures are innumerable. In terms of social support for the aged, however, what Tu's model makes clear is the importance of determining to what extent the functions traditionally performed by close kin may be performed, instead, by more distant kin.

If we view kinship as a network, we not only have to extend our concept of family beyond the household to include a variety of family types apart from the elementary nuclear form, but also have to see relations between the aged and their kin as systems involving exchange of help between two parties -- the recipients of care and the providers of care.

The concept of nuclear family is insufficient, and possibly even misleading as an approach to the study of kinship networks in later life. To reason in terms of a residentially-based unit consisting of husband, wife, and children is certainly to oversimplify the complexity of ties between members of modern kin groups, and it may, as well, create misconceptions about the kinds of functions kinship networks perform in meeting the varied needs of their older members. Extensive work by sociologists and social gerontologists has documented the fact that even among nuclear families in modern Western societies, children are heavily involved with their aging kin (Shanas, 1968). If family researchers are firm about any generalization, it is that "networks of 'community ties' (i.e., significant interpersonal ties extending beyond the household) continue to flourish and provide supportive resources to almost all members of contemproary societies" (Wellman and Hall, 1985).

In recent years, trends in patterns of family formation and dissolution have moved toward increases in both the number of life transitions an average individual will experience and the pace with which these take place. Greater variety in family settings has led to more families extending over two or more households, and to more families having kinship ties of greater complexity, than is the case with families formed by first marriages only.

Misconceptions about potential family support may arise from viewing kinship structure in terms of discrete relationships, involving simple reciprocal roles (e.g., husband-wife, parent-child, sibling-sibling), rather than as complex systems of interaction extending beyond close relatives sharing a common household to more distant relatives dispersed over possibly many places of residence. As well as misrepresenting the nature of kinship sturcture in the later years, such over-simplification could distort and weaken the analysis of support exchanged. When demographers suggest that the support potential of kin may be measured in terms of the numbers of close relatives, they may be underestimating both the limits to the supportive capacities of close kin and the important functions possibly -- or potentially capable of -- being performed by more distant kin.

However, trends in mortality leading to an increasing life span have important implications for the health and potential for dependency of the very old, and also for the health and capacity to furnish support of the young old, those in their late 50s and early 60s who increasingly have to shoulder the responsibility for providing care. By the same token, declines in fertility that affect the numbers of kin who may be available to care for the frail aged also affect the composition of the kinship network between whom the tasks of care-giving must be divided. The texture of kinship networks affects not only the living arrangements of the aged themselves, but also the extent and nature of the services that members of the network may be called upon to provide. Thus, the health and quality of life of support-providers is inextricably interwoven with the health and quality of life of aged support-recipients.

The consequences for familial network support systems have received less attention. Clearly kin networks can offer fewer options and resources when there are fewer members of the younger generations. All things considered, an aging couple will fare better when several children can contribute to its support. Certainly, it is easier for an aging widow to find a home with offspring when there are a number of grown children who might accommodate her. Childless or low fertility women have a higher chance of institutionalization before age 75 than do women who have 3 or more children. This illustrates another aspect of the demographic dilemma confronting kin networks. The older population has experienced not only growth but also changes in composition. An older relative today is more likely to be a woman, a widow, and very old. It is widows who traditionally have called on the resources of family support systems. The woman who has outlived her husband lacks the flexibility of nursing one another or reallocating housekeeping chores. What with her lower income, the widow may require greater attention from her family and is more likely to live in an offspring's home. Demographic shifts have meant fewer brothers and sisters with whom to share the sometimes considerable burden of physical, financial, and emotional support of aging parents. This burden is made more poignant by the realization that some of the aged are very old. No longer are the children of these "frail elderly" prime-age adults. The very old in greatest need of care have offsprings who are the "young-old" with their declining energy, health, and finances.

If family support systems are now taxed by the high ratio of aged to younger family members, the future promises little relief. Had Taiwan's vital rates for 1980 continued indefinitely, each 60-year-old woman would average 1.16 living daughters (Tu, 1985). The chances would be 92 in 100 that a 30-year-old woman would have a mother alive and 36 in 100 that she would have a grandmother still living. In fact, current fertility has fallen below 1980 rates to a level which, if sustained, eventually could achieve zero or negative population growth. Shanas and Hauser (1974) explore the implications for the aged of such a population possibility and conclude "those aspects of housing, recreation, health care, and income maintenance now provided by younger generations for their elderly parents and grandparents will need to be provided by society at large."

On a collision course with the declining number of descendants are the surer survival and lengthening life-span of the aged parents. Kin resources readily become overextended in the day-to-day care of aging relations, because there are fewer adult children to share the responsibility. Increasingly, other obligations and constraints compete with duties toward elderly family members. Growing numbers of middle-aged women are asked to choose between nursing frail parents or working to support themselves, their families, their own children. Furthermore, the extreme aged now pose an impediment to aging offspring's aspirations for a retirement free of financial cares or demands on their time.

Policy-makers cannot ignore the demographic trends that threaten families' ability to care for their frail and infirm relatives. In the future, rising numbers of very old will only increase the magnitude and complexity of providing care for the aged. Can the elderly be cared for in a manner that is both appropriate and cost-effective? Based on what is known about changing health needs of the elderly and changing demographic trends, what can be done to help families support their older members? Some specific policies to support families in their efforts to provide care and recognize the changes in the context of family caregiving are needed.

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# Family Care of the Aged in the United States

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In the United States, the family has been the primary method by which the elderly have been cared for. The basis of such care has been rooted in Judeo-Christian beliefs and strong cultural norms of family responsibility. Also important is the fact that government involvement in the care of the elderly is a relatively recent phenomenon, and -- in the past -- there were few alternatives to the care of the aged by family members.

With the passage of time in the United States, came industrialization and urbanization which resulted in greater mobility, increased housing costs (which made it more difficult to afford suitable housing for several generations to live under the same roof), and the "breakup" of the extended family. In addition to those elderly who had not married or who had no families, increased public responsibility was necessary for those dependent aged who did not have family living in close proximity to assist them.

This is not to suggest that families had or have abandoned their elderly relatives in the United States. The relationship is termed "intimacy at a distance," and the frequency of contacts and reciprocity of assistance between the aged and their families have been well-established so as to discard any notion of widespread abandonment. Simply put, roughly one-fourth of the aged live with adult children, one-fourth live independently in an adult child's neighborhood, one-fourth live within commuting distance of an adult child, and the final fourth either have no children or live great distances from their children.

Of course, with increasing impairments through time, loss of independence, widowhood, and economic problems, there becomes a greater need for assistance and support by older persons. To whom should the older person turn?

There are those who believe that families should be expected (or required) to care for their aged relatives. Such a view reflects a belief that family care -- of any and all kinds -- is superior to public-supported services and assistance. Filial responsibility is seen to be rooted in ethical, religious, or cultural imperatives and must be reaffirmed in efforts ranging from informal sanctions to public policy. Filial responsibility, too, is seen to relieve government -- at levels -- of the high costs of providing resources and financial assistance to the dependent aged. Thus, more governmental expenditures will be available for other domestic programs and for military spending. An integration of the economic and moral points of view occurs when it is asked: Why should government provide assistance to dependent aged who have adult children who can well-afford to care for their elderly parents?

It is generally known that in the United States the great majority of families would like to, and -- in fact -- do, provide as much in way of care and support to their aged relatives as they can. Contrary to what some might think, institutionalization of the aged generally occurs only after rather heroic efforts by families to maintain their elderly relatives is no longer physically, emotionally, or financially possible.

There has always been a faction in the United States who would desire to see families held responsible for the care of their aged relatives. They would like to see family responsibility mandated by public policy. This mandated responsibility had existed in many states in America in the past, when an older person could not receive public financial assistance until or unless it was determined that there was no family or the family could not afford to provide assistance. Such policies were found to be unconstitutional, and state after state struck down mandating policies for family care.

More subtle, but also infringing upon the self-determination of a family to decide on the amount of care to provide to an older relative, is the trend in the United States to provide incentives (encouragement) for family care: tax benefits, monthly financial allowances, reimbursement for care expenses, etc. While no such national family care for the aged policy currently exists, efforts are generally at the state level in way of demonstration projects or of a limited scope. While such incentives can assist some families, it is true, these efforts can be criticized for several reasons: creating the wrong motivation for family care (financial gain), forcing the aged upon their families. The assistance to families is but a pittance compared to actual expenses; the greatest "costs" of family care for the aged are not economic, but are social and psychological in nature; and public savings through such incentive programs have not been confirmed.

Family care of the aged may be required for eligibility in some community programs. Many programs and services for the aged in the United States have the eligibility requirements that families be available as the major careproviders for dependent elderly relatives. These community resources are seen to be time-limited and supplementary to family care, not a replacement for family care. Examples of such community services which often necessitate family involvement include home health care, Visiting Nurses services, day care and congregate meals programs (which do not have a transportation component) and hospice care for dying elderly persons. While, on one hand, the eligibility requirements of family care can be justified, these requirements force family care and are discriminatory against the aged without families or who have no family members in close proximity.

A popular focus among current gerontological work in the United States is on "family burden" resulting from the provision of care to dependent elderly. An increasing number of researchers have documented the strains on the family from excessive and unrelenting demands resulting from the needs of an impaired older person. The "costs" to family caregivers include physical, social, psychological, and psychosomatic consequences as well as financial strains (which have been found to be least disruptive). Even with the best intentions and motivations, and with an elaborate informal support system, families and family members can be over-burdened. The probability increases when the major caregiver has no others to assist in providing care, when the caregiver is frail (such as an elderly spouse), or when the caregiver is ill-suited to care for a vulnerable and impaired older person (i.e., a caregiver who is an alcoholic, unemployed, lacking experience as a caregiver).

The consequences of such "burdens" on family caregivers may not only be ineffective care. The ultimate adversity to an older person by a burdened or inappropriate caregiver may be elder abuse. Whether resulting from anger or frustration, the dependent older person may be especially vulnerable to abusive behavior by family members. In the United States, it is estimated that between 500,000 and two and a half million elderly persons each year are subjected to physical or psychological abuse, active or passive negligence, theft or misappropriation of possessions and assets, or denied basic rights -- often by family members. The two general explanations for such abuse include the following: first, frail aged are being cared for by family members who are unsuited to care for dependent and vulnerable persons (of any age) and second, the "burdens" of care erupt into abusive behavior.

Yet, public policy continues to emphasize family care of the aged in the United States. Discharge planners in the health care system turn "instinctively" to family members for the care of discharged geriatric patients. Social service and welfare workers view the family as a panacea for the care of multi-problem aged clients. And probate court judges seek out families to be guardians for confused and incompetent elderly. Seldom, if ever, is the family screened so as to determine how effective they will be, how burdened they are already, or how the increasingly impaired older person will affect the total family.

The message is that the family cannot so simply be viewed as a panacea or as pivotal in public policy for the care of the aged in the United Stated. Social changes in this country are further making family care less available for the aged as a result of lower birth rates, fewer divorces and remarriages which are obscuring family roles and responsibilities, multi-generational family networks in which the children of the elderly are themselves old, the continuation of geographic mobility of both the young and old (including emigration), and -- perhaps, most important -- the changes in the role of women. There is an increasing proportion of younger women who seek careers outside the home and older women who seek (after raising their children) education and careers. Therefore, women -- traditionally the most prevalent caregivers for the elderly -- will be less likely to be available to provide assistance to aged relatives.

The care of the elderly by families in the United States is at an important juncture. The push for family care, resulting from tradition, values, and economic pressures, conflicts with knowledge about the consequences on the family and aged, and with present and future changes in the family and in society. American families have not abandoned their elderly. But the extent and duration of their efforts must be carefully monitored. The balance between family care and public responsibility may be shifting toward a greater role for the government to better meet the needs of families who wish to care for their elderly relatives, and for those elderly who are without relatives, and for those elderly who are without families or whose families are unavailable, unmotivated, or ill-suited for the important role as caregiver.

# Long Term Care Issues in Florida
## Some Questions About the Role of the Family

**Richard D. Tucker, Ph.D.**
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The state of Florida is in the unique position of serving as the harbinger of aging issues and policies for the United States, and indeed for the world community. With those age 65 and older comprising almost 18 percent of the total population, and with the percentage of those 80 years and older representing the fastest growing segment of our older citizenry, Florida is currently facing issues in aging, especially the issue of long term care, that reflect projected national and world concerns in the 21st century.

The questions that are currently being raised in Florida include the following:

1. How do we meet the multiple needs of the rapidly growing population of old-old?
2. Regarding health care in general, and long-term care in particular, how do we contain the rapidly escalating costs?
3. What are the alternatives to institutionalization for those who no longer are able to care for themselves?
4. How can we best integrate the delivery of social and health services?

While it may be important for the world community to look to the Florida experience in anticipation of meeting future needs, it is equally important for those in Florida to look at the policies and practices of other countries both to learn about different approaches to meeting the needs of the elderly, and to explore the differing clutural assumptions and values regarding the aged. Given the clutural assumptions and values regarding the aged. Given the participating countries and location for this conference, of special interest is the strong role of the family in the care of the elderly. This focus is important to Floridians because one common dimension to potential answers to the questions stated above is increased involvement of the family in the care of the elderly.

Despite the demographic differences between Florida and Taiwan, what insights can Floridians glean for the questions they are currently posing? Some questions that should be pursued regarding the role of the family in the care of the elderly would include the following:

1. How has increased industrialization and "Westernization" affected family structure and the ability to care for older family members?
2. What "support systems" exist to assist the family in the care of their elders?
3. What is the role of the government in providing family based assistance and is that role changing?
4. Has the changing demography of the aged, and especially the old-old, changed the traditional family care systems?

# Financing and Delivering Health Care for the Elderly:
## Problems, Opportunities and Strategic Response

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The financing and delivery of health care for the elderly is a major issue in all developing countries. The aged, especially the 85 and over group, is growing rapidly in most countries. By the year 2000, fifty percent of all health care expenditures in the USA will be related to the care and treatment of the over 65 population. Those over 65 are hospitalized approximately twice as often as those under 65, stay twice as long and use twice as many prescription drugs. A major portion of public health care expenditures is spent on those who die within one year of the onset of an illness. Although the elderly have made remarkable strides in economic attainment in the last two decades, the public sector still pays the largest portion of their health care bill. As a group, the elderly are diverse in their needs, interests and resources. Despite chronic conditions, the majority live relatively healthy and active lives. However, a large minority of elderly require comprehensive and often costly acute and long-term care as well as the support services which are not readily available. As the population ages, the costs of providing these services within current modalities and systems will be staggering. As a result, health care providers can expect continued pressure from public and private payers to constrain the cost of health care.

A comprehensive restructuring of the currently fragmented and medically oriented health care system is required to more effectively and efficiently respond to the complex health and diverse social needs of the elderly. The acute care hospital must evolve into a comprehensive, integrated and well managed health care system which provides a full array of health care services systems. Such a system will provide a continuum of acute and long term medical services to the elderly as well as an array of other health and social services including nutritional programs, outpatient services, care management and social services, education screening programs, counseling, adult day care, foster care, extended care, housing, continuing care retirement facilities, and other skilled or in-home and community outreach services, it may be possible to finance a major share of the new array of preventive health, social and housing services through savings in the use of acute care and long term nursing services.

In addition, to meet the needs of the growing elderly population, the practice of medicine must evolve from a narrow disease treatment orientation into one that places greater emphasis on prevention and rehabilitation. Modern medicine must shift from diagnosis and treatment of disease and trauma to prevention, maintenance, and rehabilitation of chronic degenerative diseases that come with longer life.

Finally, to finance the staggering cost of the graying of health care, we must redesign private and public financing programs to cover more of the types of treatment the elderly need such as home care, long term health care, and health maintenance services. The development of new forms of insurance and the integration of insurance and service delivery systems may provide additional incentives for more efficient utilization. The development of prepaid health plans for the elderly, social HMS's and life care retirement communities could provide incentives to keep the older people healthy, active and independent. More effective leveraging of the financial assets of the elderly through mortgages and annuities, private incentives for independent pensions and retirement programs also contribute to resolution of the significant financial challenge of adequately funding health expenditures for the elderly. Collectively these initiatives may provide an effective strategic response to the major issue of financing and delivering health care for the elderly.

# The Financing of Long-Term Care

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Long-term care service represents the major source of catastrophic expenditures for the elderly in the United States. Whereas the vast majority of the elderly's hospital costs are paid by Medicare, patients and their families pay directly for about one-half of their nursing home costs. Approximately 40 percent of the elderly will enter a nursing home during their life and about one-quarter of these individuals will stay more than one year. As a result of these utilization rates, 10 percent of the elderly seem to account for 90 percent of the nursing home costs. This makes nursing home expenditures more skewed than those for hospitals.

With such a skewed distribution some insurance or risk-pooling would seem to be the appropriate financing mechanism. While insurance would increase use, we have experienced from life care communities that the expenditures can be managed and utilization kept within reasonable limits.

There has been little national debate in the United States about whether long-term care funding should be private or public. Medicare, the acute care financing program for the elderly, does not cover the chronic or long-term care services. State Medicaid programs cover such services, but only for those who are impoverished. Private insurance companies have begun to fill the void, but the policies being offered usually stop well short of the catastrophic costs. It is not clear, however, whether the reason for this lack of extensive coverage is because of the reluctance of insurers to assume risk or because individuals do not demand the necessary coverage.

The latter may be the more important factor. Most of our private insurance is sold through employers; such as health and disability. Employers or unions, who are being squeezed to maintain acute health benefits, cannot be expected to seek protection for long-term care since most of the financial risk is 15 or 20 years after retirement.

One might conclude that the elderly, whose income and assets have improved dramatically in the past 20 years, would be willing to purchase long-term protection. Since about 75 percent of the elderly mistakenly believe that that Medicare covers long-term care, it is a difficult sale. Furthermore, if only the disabled recognized the gap in protection and were willing to purchase a policy, "risk-pooling" would not occur.

If we want to overcome adverse selection and have the well elderly voluntarily enroll in a program that provides long-term care protection, we need to think of innovative solutions that probably are not restricted to long-term care. Two such programs are available today in the United States. One, the Social Health Maintenance Organization, adds long-term care services to organized health service programs. The other, life care communities, adds long-term care to housing services. Both programs integrate financing and delivery, providing the opportunity to manage the health and long-term care needs of the elderly in an appropriate manner.

Life care communities, which number over 300, have been in existence for many years and represented the only source of comprehensive long-term care protection for the elderly. Because of their high operating and start-up costs, they represent a limited solution to the national financing problem.

The Social Health Maintenance Organization is only in the demonstration phase. While it appears that chronically ill individuals can be effectively and efficiently managed in these plans, it is not clear how successful these programs will be in a competitive health care market, particularly when the elderly can opt for a more inclusive health care program after their disability occurs.

A private market solution requires an informed elderly population. Most elderly have the financial resources to pay the necessary insurance premiums. They do not, however, have the desire. This general education will take considerable time and dollars. Since the return from the increased knowledge will be of general benefit, private companies are unlikely to finance the necessary educational program. Governments are hesitant to take the lead as well, perhaps fearing that the recognition of a major financing problem could lead to legislation and increased public expenditures. And, rightly so, since, for example, there is little rationale for the Federal government to pay for acute care of the elderly and not their long-term care.

The solution to the financing problem requires leadership. In terms of the public sector, states and the Federal government can be expected to continue pointing to the other party for leadership or dollars. The private sector will continue to move slowly in response to demand. As a result of these trends, the need for financial protection for long-term care will continue to grow. As the problem intensifies, the national debate will also. Hopefully, this debate will yield some leadership.

# The Feasibility of Self-Sponsored Living Patterns by Old People of the Republic of China

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Of the old people above the age of 65 in the Republic of China, there are approximately 27 percent to 39 percent who, due to either objective or subjective reasons, could not or would not live together with their children. In this country where retirement systems are widely implemented, the living problems after retirement of old people have become more and more imperative. Though there are government-sponsored nursing institutions, the numbers of such institutions and persons being accommodated are quite low. In addition, due to the nature at the present stage of the implementation, their living patterns and conditions are much to be improved. Some old people's nursing problems other than economic factors could not be covered by the government-sponsored nursing system. Meanwhile, the self-sponsored nursing and living perspective is still a new concept in this country which is at its budding stage -- in which old people to be provided by the nursing institutions.

These institutions will take care of the living facilities and medical care activities, help the aged to overcome the suffering of loneliness, and help to maintain their independent living with a moderate sense of self-esteem. Can this new living method of old people in self-sponsored living environment be easily accepted by them? Has it become one of the nursing patterns favored by old people? Is it one of the methods that can be gladly accepted by the nursing institutions?

Based on the questionnaire sent to the 221 old people living in the "TSUI PO VILLAGE, FREE CHINA RELIEF ASOCIATION", we have conducted a general survey of their "living patterns" and "actual living conditions". The information received from the questionnaire and the research activities have been processed by computers, analyzed and concluded, then compared with the theories and ideals. We have proposed some suggestions for the self-sponsored nursing system in the sense of concept, living styles, planning and designing, living environment, and legal provisions, to serve as the reference for the setting of guidelines and policies and for future construction or planning of self-sponsored nursing facilities. These suggestions are aimed at realizing the ideal and perfection of future self-sponsored nursing system, to better satisfy the physical and psychological requirements of old people. Moreover, we hope that these suggestions may influence the government-sponsored nursing system, and further, to realize the final goals for the elimination of all problems for the hanidcapped, disabled and sick old people.

# Housing: People, Process, and Policy

**Gordon F. Streib**
**University of Florida**

## I. Housing and its Relationship to Basic Social Institutions

Housing is a subject that can be analyzed through attention to a variety of social and social-psychological issues. The starting point for our analysis is considering how housing is affected by the principal institutional structures of a society: the economy, the governmental structure, the family, and the system of social stratification. There are other institutions involved in housing, but space will permit us to only discuss briefly these four.

The economy is placed first because its level of vitality is crucial in determining the allocation of resources for housing. The government also plays a very significant role, both in the financing of housing in the United States and through various laws and processes that are related to housing. Indeed, since the United States has multiple levels of government -- federal, state, and local -- the governmental structure is extremely complicated as it relates to housing. At the local level, for example, there are enormous varieties of zoning and housing regulations that pertain not only to the elderly but to all age groups. Different states also have a variety of laws, regulations, and financial arrangements that pertain to the housing situation. The federal level of the United States has been primarily involved in setting up subsidized housing of several sorts, a number of which have been designated for older people.

Understanding the role of the family is integral to an analysis of housing, because housing is more than bricks, cement, lumber, and appliances. It involves people, relationships, obligations, and transfer of family assets. The complexities of family arrangements impinge upon the way housing is allocated and utilized in American society. Indeed, the family is often viewed in terms of a living arrangement or dwelling unit, and it is defined by determining who lives in a particular unit. Viewing housing in family terms requires us to see that housing is tied in with a life-course perspective or a family-cycle perspective. One can conclude that housing arrangements must change, for they should adapt to the changes in the creation and dynamics of the family life. Where does the new young family move after marriage? Do they set up their own residence? Or does custom determine that they move in with the parents of the wife or the husband? In the United States, analysis of family patterns is very important in understanding housing and its relationship to the elderly.

Finally, one must have an understanding of the class system and how it relates to housing. Housing is usually the most important piece of capital goods that a family acquires. It entails a lifetime of saving for many persons. Almost three-fourths of the elderly in the United States live in owner-occupied dwellings, which constitute their major economic asset. There is considerable variation in the size, quality, and livability of homes according to one's position in the class system.

## II. Where Do Older People Live?

A productive way to understand the living arrangements of older people is to view them on a continuum which ranges from the least supportive to the most supportive kind of housing. A conventional house or apartment is regarded as the least supportive, and the life-care facility or nursing home is the most supportive. The term, supportive environment, refers to the degree to which the housing provides for both the routine and special needs of the older resident, as well as the degree to which the resident has responsibility for maintaining the housing environment. Conventional housing is considered to be a single family house or apartment in which the owner assumes full responsibility for meals and other services and also takes care of the maintenance and repair of the property and garden and yard. The owner has multiple responsibilities: paying taxes and insurance premiums; maintaining the house to the standards of the local housing code; repairing plumbing, heating systems, and roof. All of these tasks are an integral and accepted part of home ownership in the United States. However, older people in declining health sometimes have extreme difficulty in coping with these responsibilities personally, or finding and paying someone to perform them satisfactorily.

Conventional housing, such as single family homes, condominiums, and apartments, comprise 80 to 90 percent of the housing of older Americans. About 10 to 20 percent of the elderly live in different kinds of retirement housing with various degrees of supportive services: retirement villages, high-rise apartments which are virtually vertical cities, retirement hotels, shared-living homes, life-care facilities, and nursing homes.

Nursing homes are the final point on the continuum. About 5 percent of the elderly in the United States live in some kind of institutional facility, principally nursing homes. Often the elderly and their kin will make compromises and consider any alternative to avoid institutionalization because of the negative perceptions held about nursing homes by both young and old people.

## III. The Housing Market

It has already been mentioned that the great majority of elderly people live in owner-occupied dwellings in the United States. These dwellings range from very small and simple single-family homes and apartments to large affluent homes and estates. The range of housing in the United States is similar to that in other industrial countries. One difference between the United States and some of the northern European countries is the presence of deteriorated or slum areas in the United States. These are not found in some northern European countries because there is a larger amount of public involvement in the provision of housing for the poor and for the elderly.

In the United States there are about 1,000,000 dwelling units that have been created by the federal government as public housing units for the elderly. Most of these projects are arranged and financed through local housing authorities, which take the initiative for creating the housing, for obtaining the financial backing, and for managing them after they are built. These projects range in size from very small projects in small towns and rural areas to very large, multi-storied buildings in our largest cities. The rents for these houses are subsidized and therefore applicants must prove economic need before they are permitted to live in a public housing project.

## IV. Combining Shelter and Care: Special Forms of Housing

One of the areas in which public initiatives and funding have been important in the United States is that of congregate housing for older people. This type of housing was officially defined in the 1970 Housing and Urban Development Act as "a kind of low-cost housing in which some or all dwelling units have no kitchens and in which there is a central dining facility." This original definition has been changed somewhat in practice, but the main point involved in congregate housing involves determination of exactly what is to be congregated -- the living units? The old people as residents? Or the services that are provided? Congregate housing means bringing the houses together. They are congregated in complexes. Another interpretation is that the old people are to be gathered together for residential purposes. Finally, the third interpretation is that the congregating is of the services rather than either living units or old people. The major point about congregate housing is that it goes beyond merely providing a place to live. It brings together a special population, the elderly, who will live together in close proximity in various kinds of buildings and in which a variety of services may be provided. In point of fact in the United States, publicly financed congregate housing has been limited in scope. The services that have been provided include: one meal a day, a small health facility, and some kind of recreational services.

Another kind of supportive environment is house sharing. This arrangement generally means living with non-related housemates in an unaltered private home. Almost any kind of relationship may be worked out between the participants, ranging from eating meals together and sharing all the household chores, to merely sharing the front entry hall and the mall box. Generally, the home owner sets the rules and defines the terms. In a sense, it is not true "sharing" but is a modification of a landlord-tenant relationship.

Foster family care is another housing alternative for the elderly that has small group characteristics and seeks to duplicate family life. Like house sharing, however, it brings together unrelated persons. Foster homes usually are a form of house sharing, but they are under closer government inspection and scrutiny. Social workers usually inspect the home and negotiate the arrangement. Public money often pays for foster family care. This represents the direct, bureaucratic intervention by the state for usually the social worker monitors the situation.

In the United States, each of our states has its own definition of foster homes and sets up its specification and surveillance procedure. Usually, however, the foster home consists of a single family household that incorporates one to four residents whose care is paid for usually by public funds. There is a range in quality of care and the kind of involvement in the family life.

Another type of supportive housing which is non-institutional and which has received attention in Great Britain and Australia is the "Granny Flat." The term was used to describe a self-contained small house -- bungalow -- adjacent to a family house. It was designed to provide housing for an elderly person -- often a widow who can no longer live independently and who needs some support from her relatives who are close at hand. Yet she wishes to maintain a separate dwelling. The concept started in Australia and it was planned that mobile units would be rented and moved to a family's backyard. When the unit is no longer needed, it could be moved to a new location to serve another family. There are many problems in the operation of Granny Flats, such as the expense of erecting and removing them. The idea has not been widely utilized in the three countries that have tried to institute programs to sponsor them.

## V. The Social Psychology of Housing

We have mentioned that housing is much more than brick and mortar, for it is the focal point in one's environment. The special quality of housing involves many facets of one's life: it represents savings, family life, and for many it becomes a symbol of not only family but one's own personal achievements. The house is of special significance to many women, for they have devoted much effort and attention to its special quality as a place for their families to to live. In the case of the elderly, the symbolic and familial aspects of the house are among the most important that need to be considered when there is the necessity to move.

Indeed, the whole area of the social psychology of housing and the difficulties that older people find in moving constitutes one of the most intriguing and important areas of practical affairs and social research. Our knowledge of this area is rather limited, but we have some basis for realizing that if a move is necessary and it is voluntary it is probably more readily accepted than if it is forced. If the decision to move is to a different environment that has features similar to the one that is left, it also is more acceptable than housing that is widely divergent from the previous environment.

## VI. Housing and Policy

The issue of mobility and the elderly is one of the most important housing policy issues on the agenda of administrators and researchers. The decision of whether one stays in one's own home or moves to another setting involves complex issues. One topic that intrudes upon the problems related to moving and policy in the United States is the fact that many elderly are over-housed; that is, they live in homes that are too big for their needs and often too expensive for them to maintain adequately. Yet they usually fiercely resist any move to housing that is more compatible with their needs and resources. The ways in which the over-housed elderly can be handled is an area that we will be facing increasingly in the years ahead as the numbers of frail older women increase.

Another important area related to policy at the present time is that the funds from the public treasury for housing have been cut severely and the number of new units that are available for the elderly and for other age groups is extremely limited.

Researchers and administrators in the field of housing for the elderly have faced the interesting issue of age segregation or age integration. Perhaps the issue should be stated in terms of age concentration rather than segregation because that term has negative connotations in the United States because of racial segregation.

Retirement communities and other age-dense residential settings have been viewed negatively by some gerontologists, sociologists, and advocates. Powell Lawton has discussed this issue and points out there are several important questions, and in weighing the evidence he argues that the issue still remains unsettled. Professionals may not agree about the research findings on the optimum retirement environment, and the elderly themselves hold varying opinions of what is the most desirable place to live.

Finally, the issues of the private and public sectors need to be considered in broad policy relationships. Housing for the elderly represents an area in which there can be both competition and cooperation between public and private agencies as they design and plan the varieties of housing that are required by the elderly and devise new means of funding and distribution of limited resources.

Our major goal is to increase international understanding as it relates to the elderly in our two countries. It will be fruitful to research plans that will be of use to both societies. I have not discussed the cross-national implication of the situation in the United States and how it pertains to Taiwan. These important topics will also be part of our continuing exchange program.

# Migration and Housing: The Florida Experience

**Aaron Lipman**
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## I. Migration

The state of Florida has a large number of elderly people among its population. The experience of this particular state, therefore, provides an excellent example of the relationships that exist between aging, mobility, and housing needs for older people. We can look briefly at some of the major demographic trends that exist in Florida, and then relate these to the issue of housing.

Florida's population is one of the fastest growing of any area in the United States. Between 1970 and 1980, the state's population increased by 43 percent! Florida also has the highest percentage of persons over 65 (18.1 percent compared to 11.4 percent nationally). These two facts are related because a substantial part of the increase in the state's population has been due to older people migrating to Florida after retirement.

In general, older people in the United States tend to be much less mobile than younger individuals. However, after retirement, many of the elderly migrate to a more pleasant climate. The generalizations can be illustrated by the following: Between 1975 and 1980, fewer than 5 percent of people age 60 and older changed their state of residence. However, among that 5 percent, nearly half a million (437,000) elderly people moved for Florida. Thus, Florida is a popular retirement area and the dominant destination of many older migrants. In fact, among the population of the state, one in four persons is 60 or older. This compares with one in nine in the national population.

If we look at the characteristics of elderly migrants within the United States, it appears that they posses elements that greatly benefit their destination state. Compared to those of similar age who have not moved, more of the migrants lived in independent households which were self supporting, and more had retired from the labor force. In addition, migrants had more years of education, had a higher income, and were more likely to be married than were nonmigrants. With their higher socioeconomic status these migrants initially contribute to the economic welfare of the state to which they move. With their significant buying power they increase the demand for housing, adult recreational facilities, and retail goods. In addition, as consumers, they force the expansion of local utilities, transportation networks, protective and health services. These benefits are compounded by the fact that these elderly migrants generally do not compete for jobs in the labor force.

However, there are also costs that accrue to the destination state. Over time, as these individuals grow older they become the primary consumers of medical services, social services and income maintenance programs. Although they initially contribute to the economic welfare of the destination state, they eventually place increasing demands on public health, public welfare and services for the aged.

Migration not only has implications for social service agencies, it has both benefits and costs for the individual. One of the obvious benefits is living in a benign climate, which is why the so-called "sunbelt" receives so many of these elderly people. The increasing leisure time available after retirement and the resources for recreation available are another factor drawing the elderly to these states. Retirement communities emphasize their year-round leisurely life style and their adults-only exclusivity.

When individuals move, they often separate from acquaintances, friends, and family members. These losses can be traumatic. However, contact can be maintained with friends and kin by phone and through short-term visits. In addition, it appears that at least half of the individuals in retirement communities have ties in these communities before they move. A common pattern is for retired individuals to visit with other retired friends and family members. After visiting the area and deciding they like it, they move to their new place with an initial network of friends and family members. This results in a general similarity of migrant background in each community.

As they age, these migrants become susceptible to the illnesses that affect the old-old. Since friends are usually of the same age category, they too are more vulnerable to morbidity and death. Many, (but not most) of these elderly, therefore, when they become older, alone and in poor health, migrate back to their home state where they may have family. My colleague, Dr. Charles Longino, analyzed the characteristics of elderly migrants from four states -- New York, New Jersey, Pennsylvania and Ohio -- from 1975 to 1980. One-fourth of Florida's out-migration went to these states.

The differences between in-migrants and out-migrants from these states were great. While only 15 percent of those moving to Florida from these states were 75 and over, more than one-third (over 33 percent) of those moving out of Florida were 75 and over. Whereas three-quarters of those moving to Florida were married, fewer than half of the out-migrants were married and nearly half were widowed. Nine out of ten of the in-migrants from these states lived independently compared to only six out of ten of the out-migrants; one-fifth of those moving out of the state were disabled. Those leaving Florida for these states had somewhat lower income and were about 5 percent more likely to be in poverty than the in-migrants. Thus, it appears that the very old, the widowed, the frail, and the poor are primarily the ones who return to their home state. This somewhat reduces the demand for health care and social services within Florida since it is the most needful who outmigrate.

The aging of these migrants also has implications for the family. Most kin networks involve considerable contact between elderly parents and their children. Parents and children manifest the greatest amount of exchange assistance within the kinship system. If there is not frequent face-to-face interaction, as when elderly parents have migrated to another state, contacts were maintained by phone calls, letter writing and visits.

When parents are in good health, they do not require frequent or extensive aid from their children. However, when parents become older and ill and in need of continuing care, they tend to return and call upon their families. Throughout the United States the majority of bedfast and homebound elderly are taken care of primarily by family members; they are taken care of at home by either spouses or children. Having elderly parents who had migrated to Florida return when they experience a health crisis, often precipitates another crisis within the extended family. The resolution of this crisis centers around the provision of continuing care and shelter for the dependent parent(s).

## II. Housing

As a consequence of these migration patterns, as well as the demographics of aging in general, the American housing industry has undergone many changes and developed a number of innovative responses. At one time in the U.S., retirement housing was a quiet field donated by non-profit groups such as churches and government who provided facilities for a needful population. Today retirement care is swinging to the profit sector of the economy and is geared to a healthy, affluent older population. The elderly as a group, both migrants and non-migrants, are likely to own their own homes. Due to special tax benefits, they also have tax-free equity to invest in new housing if they sell their homes. Many change dwellings in their retirement years. Large corporations, aware of the profit in retirement housing, have ambitious plans for this growth industry. It is estimated that more than 30 billion dollars will be invested in new homes for retirement-age buyers and renters before the end of the century. These dollars will be invested in a wide variety of housing options to accommodate the needs of differing age groups.

Retirement planners have realized that the elderly have varying degrees of need, with the likelihood of chronic illness and disability increasing with age. Accordingly, they have modified the gerontological divisions, dividing old age into three categories: early retirees (55 to those younger than 75); the old (75 to 85); and the very old, (more than 85). It is this 85-and-over group that is growing fastest in the United States.

The various housing options range to accommodate this continuum of need. At one extreme are the autonomous, independent and vigorous retirees who can care for themselves and prefer to live on their own in their own homes. This group has a variety of housing options. One of them is the mobile home. They may move to a warm climate in their own mobile homes or they may buy a mobile home after they migrate. The management corporation of a trailer park may sell mobile homes to its residents in order to control the type of housing in the park and to maintain the visual quality of the site. Under this arrangement residents rent lots from the management corporation. The residents also benefit since this reduces their property taxes; they own their mobile homes, but not the lots on which they are situated.

Other independent elderly who move to Florida may buy or rent a single-family home or apartment. Retirement housing subdivisions are also built for this independent retiree market. These retirement communities can be condominiums, townhouses, or separate single-family units, and are designed for those who seek an active retirement and do not want to rent. These subdivisions tend to be populated by people of similar age, race, religion, country of origin, occupational status, etc. Many such retirement communities have restrictive clauses excluding young children. Autonomous retirees cluster together where they find people who share a common set of values, activities, and life-styles. Most of these retirement housing subdivisions have some recreational amenities with extensive activity programs to assure a busy schedule for their residents. Some group residential housing is actually built around a community center that offers this multitude of activities.

There are also what are called congregate living arrangements for those still able to take care of themselves but unable to get around as easily as they had before. They may require assistance in housekeeping and the preparation of meals. These congregate living arrangements usually offer easy access to and available medical care.

Retirement hotels offer still another alternative to the semi-independent retiree who wishes to rent. In most respects these facilities function as hotels, with maid service and meals available. They may also provide health-care services tailored for the elderly.

For those who are more seriously impaired, another alternative is the separate apartment community on or near a major medical facility. Here, intermediate and/or nursing home care is offered. Such facilities that are variously known as respite-care, assisted-living and catered-living arrangements are designed for individuals who are more advanced in age and more functionally dependent, but who do not want an institutional ambience in their living quarters. The intermediate care residents may need help in areas such as dressing, eating, bathing, cooking, and household tasks. The catered-living concept is intended to provide such services in a home-like non-institutional setting when and how the residents want them.

A final housing option for the elderly is the life-care community. The life-care community provides for nearly every contingency in an older person's life, and offers a guarantee of care until the individual leaves or dies. Meals, transportation and medical care are all part of the commitment. Every life style requirement is met from the design of the living quarters to the presence of a fully-staffed central medical facility. One of the major components of a life-care community is the community's own on-site health center.

A major problem facing many of these communities is the aging of their resident population. When residents age they have different needs from those which attracted them to the community in the first place. As time passes, the median age of cohort increases. This creates marketing difficulties, since it acts as a barrier to attracting younger people into the facility. To keep themselves cost effective, housing that caters to the elderly, especially life-care communities, requires a balance between younger, less needful residents and the functionally-dependent elderly.

Most of these housing arrangements represent accommodations to the perceived needs and desires of a rapidly-growing population of retired and mobile elderly. As these conditions change, housing is being constantly challenged to find new modifications.

# Advent Christian Village - More Than Housing

**J. Pomeroy Carter**
**Advent Christian Village, Florida**

## Introduction

I deeply appreciate the opportunity I have been given to describe the rather unique program which has been developed at Dowling Park, Florida -- The Advent Christian Village.

The Village is unique in several ways:

1. It is unique in the way it has developed partnerships to meet the needs of older adults and troubled youth.
2. It is unique in its continuum-of-care concept.
3. It is unique in its intergenerational make-up.
4. It is unique in its socio-economic mix of residents.

## I. Unique Partnerships to Meet the Needs of Older Adults and Troubled Youth

To appreciate the uniqueness of the partnerships which exist at the Village among our particular Church group, governmental bodies and private individuals, one has to be aware of the traditional separation of church and state in our country. The desire for religious freedom motivated many of the early settlers to leave Europe and begin new lives in the United States. Religious freedom first triumphed in the Commonwealth of Virginia when Thomas Jefferson's "Bill for Establishing Religious Freedom" was passed and became a law on January 19, 1786. It soon spread throughout the nation, and a few years later in the form of the first amendment to the Federal Constitution became a fundamental law of the land.

Jefferson's part in this accomplishment was not so great as was that of James Madison, nor were both as important as was that of the people called Baptists. Before the Declaration of Independence, the Baptists stood alone in demanding the separation of church and state. It was from the Baptists that the Advent Christian Church directly evolved in the mid-1800's.

Although most American churches continue to advocate the separation of church and state, some are more willing than others to enter into partnerships with governmental organizations to provide social services to the elderly.

Traditionally, church groups in America have served the elderly by developing Life Care Communities where older persons are required to pay a substantial sum upon admission and continue to pay monthly maintenance fees for the remainder of their lives. Many religious organizations chose this method of financing their programs in lieu of becoming entangled with government regulations which are inherent with accepting government loans and grants. The Village, also, pursued this course from its beginning in 1973 until the early 1950's.

Most religious organizations operate high quality programs but Life Care Communities, of necessity, are limited primarily to the more affluent. The rest of the elderly needing institutional care are forced to live in free standing proprietary or governmentally sponsored housing projects, boarding homes and/or nursing homes. In 1959, while doing intake studies at the Jewish Home for the Aging in Miami while I was a graduate student in the School of Social Welfare at Florida State University, I became aware that most of the elderly with whom I was talking were basically desiring the same thing. While they were still active and alert, they wanted to get settled into a secure and affordable place where they could receive the services they would need as they grew older and less self-sufficient.

I was attending graduate school to prepare to become the Chief Executive Officer at Dowling Park...The Advent Christian Village. During those days, I began dreaming about a community with a comprehensive array of affordable services -- a place where retired persons from various socio-economic backgrounds could relax and enjoy living with the assurance that they would be able to remain at the Village for the rest of their lives. It soon became obvious to me that it would be difficult, if not impossible, for a small church group to develop and maintain a Life Care type of Community which older persons with limited incomes could afford. Yet, there were members of the Villages' Board of Directors who feared that the Village would lose control of its programs if governmental funds were used. They maintained the traditional stance of the separation of church and state. As an alternative, they chose to develop programs which would most quickly produce additional income. They voted to build garden apartments and to expand the Nursing Home so persons from the surrounding community could be served.

It was somewhat of a blow when we learned that older persons from the area could not use their Medicare or Medicaid benefits except in appropriately certified Nursing Homes. There was no way the Village could serve them and its own constituency without income from Medicare and Medicaid vendor payments. The Board reluctantly decided to apply for certification. Later, as the Board wrestled with plans to expand the Village's facilities which were already in great demand, it was realized that 40-year, one percent interest loans and up to 50 percent matching grants could be obtained from the Federal Government to build and renovate facilities for the elderly. A little research revealed that regulations associated with these grants and loans were not unlike those under which we were already operating as a certified Nursing Home. Thus, after much thought and deliberations, the board of Directors, which sincerely desired to serve persons from all socio-economic strata, voted to enter into partnership with the government in order to develop a comprehensive community with an affordable continuum of care.

## II. Continuum of Care Concept

There are few services and facilities at Dowling Park which cannot be found elsewhere. Typically, however, such services stand alone as independent, fragmented programs instead of being formally related to and coordinated with other services to form a continuum of care. It is the availability of this comprehensive array of affordable services which make the Village unique and provides security to its residents. Briefly, the components of the continuum are as follows:

A. A variety of Housing Options - Persons over sixty years of age are as diverse in their preferences as any other age group. That is why we have attempted to provide the following variety of suitable housing options.

1. Land Lease Houses

The Land Lease Housing Program offers residents the opportunity to have and live in their own custom designe single dwelling house constructed on leased land. To date, thirty-eight of these homes have been built and each is as different as the personalities of their owners. These facilities have, however, certain required safety features, such as wide barrier free doorways, baths for the handicapped, emergency call systems and automatic smoke and fire alarms.

2. Cluster Houses

Cluster Houses are different from the land lease homes in that one and two bedroom apartments are constructed by the Village and are readily available for purchase by prospective residents who do not desire to go through the hassle of building their own homes.

3. Manufactured Houses

A thirty-eight lot Mobile Home Park was constructed several years ago and is available for those who prefer to live in their own manufactured houses.

4. Garden Apartments

There are twenty-four garden apartments for those preferring to live at ground level in rental units.

5. Mid-Rise Apartments

When the Administration of the Village chose to serve persons from various socio-economic backgrounds, it applied for two long-term, low interest loans from the The U.S. Department of Housing and Urban Development. The first loan was obtained in 1973 and the Dowling House, which is an eighty apartment, H.U.D. #236 Project with a rental assistance program, was opened in

June of 1974. In 1981, another loan was secured, and the Carter House, which is a hundred apartment, H.U.D. #202 Project with Section 8 financing, was opened in October of 1981. These facilities are located at the center of the village and are physically attached to each other, to the Civic Center/Cafeteria, the Out-Patient Clinic, the Intermediate Care Facility and the Skilled Nursing Home. Low income residents in the H.U.D. facilities do not have to pay more than one-third of their monthly income for rent and utilities.

6. Assisted Living

Those needing personal assistance, supervision and continuous nursing care live in Wilson Hall, a sixteen bed intermediate care facility, and/or in the J. Ralph Smith Health Center, a ninety-two bed skilled nursing facility. The Health Center was opened in 1975, and the construction was partially financed by a 50 percent matching Hill-Burton grant.

Unlike most long-term care programs, our Nursing Home is not a "one way street." We have been able to reverse the flow. During the past six months, we have averaged almost as many discharges as we have deaths. However, there are those who reach the point when they can no longer live self-sufficiently without personal assistance or nursing care.

B. Supportive Services - The philosophy of the Village is to help older residents remain self-sufficient and living in the least restrictive environment possible.

1. Community Care for the Elderly

Having become convinced in the 1960's from our own experience that residents can be kept out of Nursing Homes and can remain in their own homes longer if supportive services are available, we became avid advocates of Florida's Community Care for the Elderly Program. We filed an application with Florida's Department of Health and Rehabilitative Services to become one of the first demonstration projects when the Community Care for the Elderly Program was initiated. We received the grant and began providing to "at a risk persons" on a seven day per week basis: 1) Case Management, 2) Chore Services, 3) Day Care, 4) Delivered Meals, 5) Homemaker Services, 6) Medical Transportation, and 7) Personal Counseling. The program immediately proved successful and was later converted from demonstration to permanent status. Today, we not only serve residents of the Village but older adults in the general community within a five mile radius of Dowling Park.

More recently, the Village was awarded another grant from Department of Health and Rehabilitative Services to develop a Community Service System for the elderly in all of Lafayette and Suwannee Counties. Workers in his program serve primarily as Case Managers who assess the needs of the older citizens and help them obtain the services they need to remain self-sufficient. This program of early intervention is designed to prevent complications and debilitating illnesses which often lean to unnecessary institutionalization.

2. Out-Patient Clinic

Throughout the 1970's, medical services were provided on a limited basis to the residents of the Village by teaching physicians and medical students from the University of Florida College of Medicine. In 1981, a gift from Mr. Bernie Copeland of Jacksonville, Florida, made it possible for us to have a well equipped Out-Patient Clinic; and we were able to employ the Village's first full-time physician who was willing to live at Dowling Park. This added a significant component to the continuum of care, and it afforded the residents a sense of security.

New residents of the Village are given complete assessments when they arrive. A plan of care is developed to assist them in living at their optimum level, and appointments for subsequent check-ups are scheduled as indicated.

The significant results of this prevention and wellness program are that more residents are remaining in their own homes. The average age of those living in the mid-rise apartment complexes is 81.2 years. Of the eighteen residents who died this year, only half of them resided in the Nursing Home, and some of those were admitted only a few days prior to their deaths.

Those who must be admitted to the Nursing Home tend to be older, sicker and stay for a shorter period of time. The average age of our Nursing Home residents is 85.5 years.

## C. Additional Services and Shops

### 1. The Village Square

The Village is unique in that it is more than a typical institution for the elderly. With the addition of the Village Square in 1983, the Village became a rather complete and self-contained community. The residents can now conveniently obtain most of the essential items and services they need at the Village Square's Grocery Store and Market, Apothecary, Branch Bank, Post Office, Beauty Parlor, Barber Shop; Crafts, Gifts and Thrift Shops, Lodge and Cafe.

A Service Station and Garage for vehicle repairs is planned for construction this year. Rental office space will also be made available for a Lawyer, Certified Public Accountant and Insurance Agent who may desire to provide services at the Village on a one day per week basis.

### 2. The Residents Council

The Residents Council is made up of elected representatives from all areas of the Village. It serves as an important link between the residents, the administrative officers and the Board of Directors of the Village. The President of the Council attends the meetings of the Board of Directors, and a Village Administrator attends the monthly meetings of the Council.

The Residents Council plans and coordinates most of the resident's activities and solicits volunteers to serve where needed throughout the Village. The residents publish a weekly newssheet, operate a closed circuit television studio, manage the Crafts Shop and Thrift Shop at the Village Square, and assist in providing many of the Village's supportive services. They designated 1986 as the "Year of the Volunteer".

## III. Socio-economic mix of Residents

The Advent Christian Village was founded in 1913 by Dr. Burr A.L. Bixler, a young clergyman of the Advent Christian Church. He established a home for children, initially, in response to the pleas of a dying mother of five children who obtained a promise from Dr. Bixler that he would care for her children when she died. About the same time, Dr. Bixler and his contemporaries realized a similar obligation to provide a home for destitute workers who had spent their lives in service to the church. As time passed, they became aware that there were, also, older lay persons in the church who lived alone and had no one to assist them. Thus, the facilities and programs of the Home for the Aged were developed and enlarged to serve them. The caring concern expressed in Dr. Bixler's founding vision has expanded well beyond denominational boundaries to embrace men, women, and children from various economic, geographic and religious backgrounds. Today, the Village is serving over six hundred persons who live in the Village and many others from the surrounding area.

A. Economic Background of Residents - The village has always operated with an informal policy of pay according to ones ability to pay. Persons desiring subsidy are expected to use their personal resources first, avail themselves of government subsidy programs when necessary, and then the Village through its benevolent fund attempt to pick up and absorbed the balance of expenses incurred at the Village.

In 1983, 70 percent of the one hundred and two Nursing Home residents were on Medicaid. Today, over 60 percent qualify for this type assistance. Our cost of care, however, always exceeds the amount Medicaid will pay, and there have been times when we have subsidized these recipients $200 per month or more in order to provide the quality of care we think humans deserve.

Eighty percent of the residents in the Carter House receive rent subsidy, and fifty percent of those living in the Dowling House receive similar help. Overall, there is a fairly even distribution between the lower, middle and higher income residents at the Village. The lower level includes persons with annual incomes below $10,500; the middle group includes those with annual incomes between $10,500 and $15,500, and the higher level group is composed of persons with incomes over $15,000 per year. In addition to the governmental subsidy programs, the Village raises approximately $300,000 annually to supplement the care of those who are unable to pay their way. There is a genuine spirit of community at the Village, and there is a lot of unselfish sharing among the residents.

B. Geographic Backgrounds - A few years ago the geographic spread for residents of the Village was divided into three areas, the local six county-Suwannee Valley area, the rest of Florida, and out-of-state. To my surprise, the residents fell almost equally into these three divisions:

| | |
|---|---|
| Local six county area | 23% |
| The rest of Florida | 41% |
| Out-of-State | 34% |

The shift from local to the rest of Florida is due primarily to the increased number of residents who come from Gainesville and Alachua County. We attribute this shift to the Village's long standing affiliation with the University of Florida College of Medicine in that county and the referrals which developed from the faculty and staff. It may be of interest to learn that ninety-six percent of the Village's residents were born in the USA. The remaining four percent come from the following countries: Canada, Ireland, Scotland, England, Germany, Finland, Norway, Denmark, Latvia and Spain. Having people from such diverse backgrounds provides enrichment for the residents of the Village.

C. Religious Background - Between 40 and 50 years ago, the Village opened its doors to persons of differing religious backgrounds. Today, the mix is as follows:

| | |
|---|---|
| Advent Christian | 45% |
| Baptist | 18 |
| Methodist | 14 |
| Presbyterian | 8 |
| Other Protestant | 8 |
| Catholic | 1 |
| Non-Affiliated | 6 |
| | 100% |

The Bixler Memorial Chapel provides for associate membership so persons will not have to give up affiliation in their own churches in order to be actively participating members at the Village. At present, there are seventeen different denominations represented among the associate members of the chapel. The Bixler Memorial Chapel has been expanded from a two hundred-and-fifty to a seven-hundred-and fifty seat sanctuary.

## IV. Inter-Generational Make-up

### A. Historical Perspective of the Children's Program -

In 1914, when the founders of the Advent Christian Village established an orphan's home, the needs of children who had lost their parents were relatively simple and basic. The orphanage gave them food, shelter, clothing, education, spiritual guidance and love, and when they were old enough, they were sent out into the world to fend for themselves. Time passed, and the world began to change into a more complex place at an accelerating pace. We changed, too. The orphanage dormitories were replaced by cottages designed for family-style living, and we began serving a different kind of child. Few were orphans. Many came from broken homes. Some had been abused and emotionally scarred. They were described as dependent and neglected.

These youngsters required a more intensive type of care, so we altered our methods to provide a greater amount of counseling and professional guidance. We also enhanced the reputation of the Village as a model of compassionate, competent caring.

Today, because our world is continuing to change at a frightening clip, it has become necessary for us to make further changes. Many of the children who need our help now are no longer merely dependent and neglected. They are the products of a nuclear age in which traditional institutions such as the family are breaking down at an alarming rate.

A substantial number of today's teenagers are confused, hurt, angry and deeply troubled. Their problems are more complex and severe than those of previous generations. And, to meet their needs, we are offering them therapeutic types of treatment, as well as traditional loving care.

Unlike the earlier years, the therapeutic treatment for many of the youth is provided by the state through purchase of service agreements. Consequently, we have developed a new concept. It is called the Eagle Bend Youth Continuum, and it enables us to give deserving youngsters a wide range of options. Eagle Bend permits us to accept children we could not have helped in the past. It also enhances our commitment to quality child care, increases our enrollment and income, and broadens the Christian outreach our founders started almost three-quarters of a century ago.

B. Inter-Generational Make-Up - Having the youth of Eagle Bend, the children of the Wee Care Center, and young adult and middle aged staff with their families living at the Village alongside the retirees is a unique and desirable mix. With the Village Lodge and Camp Suwannee drawing persons of all ages -- especially youth at the Camp on weekends and during the summer -- the Village is a stimulating and enriching place to live. It adds sparkle to retirement life and reduces the sense of isolation so prevalent in many retirement situations.

Special activities are planned during holidays, and programs are often presented at the church which bring the different age groups together just enough to meet each others needs but not so much that they get in each others hair.

Opportunities for the senior residents to occasionally volunteer their services rocking infants at the Wee Care Center, tutoring on a one-to-one basis in Eagle Bend's Sprint School, and giving the child care workers in some of the cottages a night out helps the residents feel they are still needed and have something to contribute.

## Conclusion

During its nearly seventy-five years of service, the Advent Christian Village has established a reputation for creatively responding to emerging areas of human needs. Aggressive leadership by its Board of Directors, professional staff and Administrative Officers, cooperative arrangements with other helping agencies, and a willingness to try new concepts; have kept alive and fostered the spirit of compassion and concern which motivated the Village's original founders. It is clear that new models of health care, service delivery systems, and cooperative partnerships between the church, governmental and private funding sectors will continue to be required if we are to effectively cope with the world's aging population.

It is my hope that the Advent Christian Village will continue to be in the forefront of that quest through its innovative services and educational programs.

# Elderly Housing: Design Issues and Implications[1]

**John R. McRae**
**Mississippi State University**

There is a critical need for understanding and meeting the needs of the elderly through architectural design. The emphasis needs to center on important characteristics of space planning and the ways in which people interact in the environment.

Researchers have clearly shown that the physical environment interacts with personal characteristics in influencing human behavior. As people grow older, they typically spend more time in their immediate physical setting, and their behavior may be more directly supported or limited by its characteristics. During advanced life stages we know that options are often reduced by losses, whether physiological, economic, sociological or psychological. As a simple example, a home that once adequately met the needs of its owners might now no longer adequately serve its owners if they cannot negotiate steep entry steps.

With the elderly, as with all other age groups, it is important that they be able to maintain a maximum amount of control in their living environments. Clearly articulated spaces with an optimum possibility for choices are an important factor in perception of control and facilitating interaction.

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[1] From material developed by John R. McRae, formerly Chairman, Department of Architecture, University of Florida, and Dr. Joyce Parr, Director, Foundation for Aging Research, Clearwater, Florida.

There are essentially three types of spaces that the designer is concerned with in developing a building envelope -- (1) Stable space, (2) Transitory space, and (3) Linking space. Each of these types of spaces has special implications for the elderly.

A stable space is a primary space and is served by the other two types. A stable space generally has a clearly defined set of primary human activities for which it has been designed. It may range from a senior center auditorium to an intimate bedroom balcony.

A transitory space suggests directional movement along a prescribed path. This is a space which serves the stable spaces. It may range from a colonnaded walkway to an interior corridor.

A linking space has the primary function of presenting choices and serves to connect transitory space with stable space. A linking space promotes a pause for decision-making or provides a psychological buffer. An elevator lobby is a good example of a linking space. The characteristics of linking spaces are particularly critical in influencing whether and how stable spaces are used. Linking spaces are, in a sense, the forgotten spaces in design, particularly with respect to design or the elderly. They provide choices and this is critical to an older persons' "expectancy of control" of space. They also provide potential for spontaneous interaction as in the unexpected meeting of friends in a community center lobby.

In each situation, spaces facilitate or inhibit the ability of people to use them to meet their needs. As indicated earlier, the characteristics of those spaces determine, to a large extent, the degree to which people feel they can use or control their environment.

A counseling space might be paralyzed by low partitions which too easily permit sound transmittal to an adjacent space.

Discussion about linking space can be extended further and applied to work done by other researchers. In Shared Spaces in Housing for the Elderly, Sandra Howell describes four environmental zones - public, semi-public, semi-private and private. The shared spaces (first three categories) are even more dependent on successful linking spaces than is the private zone. Clearly articulated spatial zones and clarity of choices are very important in the public zones. In these shared spaces there needs to be provided psychological cues for spatial movement by people with divergent needs. The private zones, on the other hand, require fewer linking spaces because there is an intimate and definite element of control in all spatial movement.

In addition to architectural spaces there are, in all buildings, the elements which enclose spaces. These are no less important as the two aspects - and elements - are interlocked, by their nature. Elements in design include, among others, edges, seams, filters, couples, and locks. Some brief definitions follow:

An edge is a clearly defined boundary between spaces, highly articulated such as a row of seating separating a walkway from a lawn.

A seam is a hidden boundary between spaces and therefore has much potential for being psychologically descriptive of individual and group activity. In a multi purpose room TV viewers can effectively control the entire space, negating active use of the card areas, for example.

A filter is an element which allows or evokes one space to visually leak into or penetrate into another space. A screen wall along a corridor might act to set off a dining space while encouraging visual access.

A couple is a connecting element or device between spaces, such as a door or passageway. A lock is a special kind of couple to clearly separate one space from another in a private manner, to signal controlled flow - as in a recessed entry to a private office.

We have looked briefly at the way in which physical environments for the elderly may be organized to positively influence human behavior. A clear understanding of how spaces are formed is important to making correct design decisions - decisions which support rather than constrain the ability of older people to use spaces to satisfy their needs and desires.

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# Geriatric Residential and Treatment Systems:
# Florida's Unique Mental Health Program for Seniors

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Deinstitutionalization is the word used to describe the process of depopulation of the state mental hospitals in the United States. This movement began in the mid-1950's and has had enormous impact on services to the mentally ill patients in state hospitals in the United States..."[1] In 1968, the figure stood at approximately 400,000; in 1974, 210,000. In 1980, "...at any given time there are approximately 132,000."[2] The census continues to decline.

"The national pattern of a diminishing state hospital census was mirrored in the State of Florida. The state hospital population in 1963 stood at 9,821. By June of 1983, it had been reduced to 4,320. The magnitude of this achievement can be gauged from the fact that the population of Florida more than doubled in those years."[3]

Factors in the rapid decrease in the census of state hospitals include the following: the rise of the community mental health movement; development of medications to control many of the problem behaviors associated with mental illness, as well as the illnesses themselves; adverse publicity regarding the nature of treatment in state institutions; an increasing emphasis on the civil rights of the mentally ill; and financial considerations, as the cost of maintaining large mental hospitals increased alarmingly.

For seniors, two other factors played a large role in the deinstitutionalization process. The Social Security Amendments of 1965 "...financed a means by which indigent patients could be transferred from state hospitals to nursing homes. This was an appealing alternative to institutionalization, because it was financially rewarding both to the State and to the nursing home industry."[4] "The passing of the amended Title XVI of the Social Security Act in 1973 provided a federally guaranteed income to the aged, the blind and the physically disabled. The lack of financial resources had been a major barrier to the discharge of many patients who did not meet the criteria for admission to a nursing home."[5]

The deinstitutionalization process created almost as many problems as it solved, at least in the beginning. Many former patients were placed in totally inadequate and/or inappropriate settings, where little or no treatment was provided. Some were released to families and communities that were unable to provide the care these individuals needed. It appeared that here was "...a national non-policy on mental health that releases mental patients into community facilities that don't exist, and protects their right to treatment by denying them publicly provided health services."[6] The explosion in the number of homeless persons wandering the streets of our cities is blamed, in large measure, on the deinstitutionalization process nationwide.

The State of Florida lagged behind some other sections of the country in initiating the deinstitutionalization process. In so doing, it learned from the mistakes of others. An excellent network of mental health centers and clinics had been established throughout the state. Patients released from state hospitals were referred to agencies where they received appropriate services.

Though such a network of services did exist in Florida, the State's seniors were grossly underserved by those programs. A combination of prejudice against the elderly (ageism) on the part of mental health professionals and a reluctance on the part of seniors to use community mental health services resulted in a considerable gap between the needs that were recognized and the services that were provided or used. Steps were taken to correct this problem in 1974, when the State Legislature appropriated almost $1,000,000 for specialized gerontology mental health programs in outpatient settings around the state. In addition, the Florida Mental Health Institute was founded at about that time, with a mandate to improve the mental health delivery system throughout the state. A gerontology program at the Institute addressed the special needs of the elderly and has become a model and a training center for such programs in both state hospitals themselves (pre-discharge units in particular), and at the State's mental health centers and clinics. In 1977, The State appropriated funds to convert a former 100-bed hospital into a modern geriatric treatment facility, with a program based on the one at the Mental Health Institute.

In spite of the number of programs instituted to serve the mental health needs of seniors, it appeared that serious gaps still existed in the system. These gaps prevented many elderly from leaving state hospitals or, at best, meant that those who were released were not receiving the services they needed. The Geriatric Residential and Treatment System (GRTS) was designed to close those gaps and to make it possible for large numbers of elderly inmates to be released to settings where their special needs could be met. The intent of GRTS was to test the feasibility of an alternative to hospitalization which provided a continuum of residential, social, vocational, day treatment and case management services in community settings. At present, nine such systems are operating in the state, making these specialized programs accessible to a high percentage of those who need them. Though each system has developed its own distinct character, all follow a basic pattern. On the residential continuum, the professional group home provides the most highly-structured, closely-supervised setting. Former state hospital patients, as well as those from the community who are at risk of hospitalization, receive the care and support they require, but in a non-traditional setting. As these residents improve - higher levels of skill in performing activities of daily living, increasing ability to become involved in a community - they graduate to the intermediate group home, then to the supervised group home, supervised apartments, satellite apartments and eventually (and ideally), to the community itself. The amount of independence and responsibility assumed by each client increases. Those clients who experience set-backs in their progress through the system are permitted to return to the residence which provides the level of structure and supervision which that client might need at that time.

Day treatment/day education programs provide classroom settings, group therapy, socialization and introduction to the larger community, with the programs geared to the needs and the readiness of each individual client. Case management services are available as soon as a client enters the system, providing assessment, planning, linking, monitoring and advocacy for each. This program component is a vital element in maintaining the continuum of care which each GRTS asks to provide.

"The GRTS components are structured to provide a continuum of opportunity which supports and encourages residents to move to the highest level of independence that each is capable of achieving...Within the GRTS philosophy and structure, there is the flexibility to adapt a project to local conditions, to the needs of its residents, and to new knowledge and treatment approaches."[7]

The official evaluation of deinstitutionalization projects in Florida, published in 1984, includes the following statements about GRTS: "GRTS projects significantly increase hospital discharges...From a rudimentary analysis, it appears that...GRTS projects offer not only a cost advantage over state hospitalization, but a cost-effective advantage as well...After four years, there is no doubt that...GRTS projects are accomplishing that which they were intended to accomplish: to provide an enhanced quality of life for the chronically mentally ill while offering each client the chance to reach his/her maximum potential...The 3,203 civil clients who continue to reside in the State's institutions will assuredly benefit from the carefully planned expansion of these unique and effective programs."[8]

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5. Ibid., p. 9.

6. Henry Santiestivan. *Deinstitutionalization: Out of Their Beds and into the Streets* (Washington, D.C.: American Federation of State, County and Municipal Employees, 1975), p. 11.

7. Sullivan, *Handbook*, p. iv.

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# Housing of Black Aged, Revisited

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Studies in the 1960s and 70s have established several facts about the housing patterns of the black aged: (1) nearly 75 percent own their own homes (Carp, 1969); and (2) most remain in their own homes near lifetime friends, relatives and familiar surroundings until they die or until their care is beyond the capacity of family members, (Aiken, 1982). A theory of long standing is that familism plays a large part in the selection of housing arrangements for black elderly, suggesting that separation from the homestead into public housing or other forms of care is a clear indication of lack of caring by the adult children for the well being of elderly parents. The literature offers several explanations for the scarcity of blacks in institutional care. Kalish (1971) and Jackson (1972) believe that the strength of the extended family helping network reduces the frequency of outside care for black aged. Jackson further suggests that the cost of care, i.e., special housing, nursing homes, is beyond the means of most black elderly.

In the meantime, the habitat of a large percentage of black aged is continuously described as being in dilapidated and in deteriorating neighborhoods, (Kent and Hirsch, 1971; Aiken, 1982). Government statistics indicate that 30 percent of housing units for the elderly are substandard, unsafe, and in ill repair; many lack private bathrooms, hot water, and other conveniences that Americans have come to expect (U.S. Senate Special Committee on Aging, 1977). These facts, combined with increases in the number of older people and the rising cost of housing, have created a high priority for housing among the many federal programs concerned with older Americans.

Several social and economic factors, which have developed within the past few years, may have altered the housing patterns for older Americans and for black aged in particular. A variety of housing programs are currently available to government and private sector developers. Condominiums and apartment complexes have been adapted to the special needs of older persons. Shared housing arrangements are numerous for the self sufficient and as foster care. Employment opportunities for younger black family members may have reduced the availability of family care for older parents, with persons moving to other cities, or women no longer at home who continue to live in the same cities. The issue of housing for elderly blacks is revisited to determine if these factors have suggested use of other forms of housing among the elderly in black families.

This study is seen as pilot in nature to determine the need for a full scale investigation. A simple survey of the housing arrangements for the black elderly would provide data on current utilization patterns. However, since Tallahassee is a small Standard Metropolitan-Statistical Area with a limited number of housing programs in use, it was felt that greater potential change may be reflected in the minds of the adult children, who may have some measure of responsibility with planning assistance with their elderly parents. Thus, data would include both current and projected utilization patterns. At a later point the perceptions of adult children could be compared with those held by the older parents for a measure of congruence.

## Methodology and Sample Selection

This pilot effort used parts of the interview questionnaire developed by Victor G. Cicirelli (1981). The population to be studied is middle-aged adult children who have at least one parent living within 150 miles of Tallahassee, Florida. Adult children will be sampled, from low and middle income neighborhoods to assess selection of housing options as explained by economic status. On a map of the city, major residential areas were identified for black citizens. The estimated value housing stock was used to identify low and middle income neighborhoods: $25,000 being average for low-income areas, and $70,000 for middle income homes. Ninety-three blocks were classified as low-income and thirty-three blocks were defined as being used by middle income families. The field interviewer then canvassed randomly selected blocks to find twenty-five middle aged adult children in both income neighborhoods.

The interview questionnaire used in the Cicirelli study was very comprehensive, involving three distinct objectives, (1) determination of characteristics of the adult children (2) assessment of the interpersonal relationships between adult children and their elderly parents, and (3) determination of just how much help the adult children were giving their parents at present, as well as the amount of help which they felt committed to provide at some future time when their parent's needs were greater.

Although all of these variables are important, and each serves to check out the accuracies of the other, it was necessary for us to limit our interview questionnaire in relationship to items tested and field service available. The reduced and adapted instrument sought

(1) to determine the characteristics of the adult children and (2) to focus on their helpfulness to older parents in personal care, health care, housing and home repair. The items on personal and health care were included to assess the level of personal commitment available from respondents. Additional items asked the adult children to anticipate the future housing needs of their parents.

## Characteristics of the Sample

After eliminating five interviews because of discrepancies in the data, a total of twenty were used for analysis: eleven in the low income group and nine in the middle income group. Respondents in both income groups resemble characteristics expected in the general population. The low income group was over-represented by female respondents (nine out of eleven) having a mean age of 47.4, a mean educational level of 10.5 years in school and eight female respondents came from families averaging 5.7 children. Eight respondents had children still at home ranging from one to four, (one respondent was an only child and had no children of her own). Two were currently married, two separated, three divorced, one widowed and one was cohabiting. The two male low-income respondents shared demographic characteristics with the females, differing primarily on level of educational achievement; both were high school graduates, one having had two years of college work.

The middle-income group was even more homogeneous on demographic characteristics than the low income group. Again females represented seventy-seven percent of the sample (seven of nine) with a mean age of 50.2 for both male and female respondents. The families of orientation had children ranging from one to seven with 3.5 being the mean number of children in early families of respondents. Procreative families were smaller, no respondent having had more than three children. Five persons had one child still at home, three other respondents were still caring for two children each. All were professional persons, fully employed. Two respondents were divorced and seven were married, currently living with professionally employed spouses.

## Characteristics of Elderly Parents

Low-income respondents discussed ten elderly mothers and one father. Middle income respondents discussed seven elderly fathers and two mothers. This difference may relate to the established survival patterns of low-income black women. The literature, however, does not suggest similar survival of middle-income males. The mean age of parents for low income respondents was 74.9. The same statistic for middle-income persons was 75.6.

Only two of twenty (total) elderly parents participated in the labor force, one full-time, a 63 year old mother doing maid's work and the other a 68 year old father doing yard work. The mother was a relative of a low-income respondent, the father was related to a middle-income respondent.

Educational achievements for elderly parents was quite different as reported by respondents from the two income groups. The average number of years in school for low-income parents was 7.6 and 11.3 for middle-income parents.

Table 1 below indicates the living arrangements of parents as reported by both income groups.

Table 1

Living Arrangements of Parents by Income Groups

| | Low-Income | Middle-Income | Totals |
|---|---|---|---|
| Living in own home | 3 | 6 | 9 |
| Renting apartment | 3 | 0 | 3 |
| Living with adult child | 2 | 0 | 2 |
| Nursing home | 2 | 2 | 4 |
| Other* | 1 | 1 | 2 |
| TOTALS | 11 | 9 | 20 |

*Other: Low-income--This mother is kept for several months by each of her seven children, although she owns her own home.

Middle-income-- This 61 year-old father is living in the home of his mother who is the head of household at 82.

## Perceptions of Housing Needs for Adult Parents

Except for the four parents currently residing in nursing homes, respondents in both groups regarded their parents as in good health with little indicated need for assistance. Most were provided with transportation to church, for occasional shopping and visits with friends and/or relatives. Respondents were asked two questions which gave them opportunity to identify future housing needs of arrangements for their parents:

1. Under what conditions would your parent need to move from his/her present residence?

2. What arrangements will be made for your parent when these conditions occur?

Considering the many discussions in the literature regarding the inability of older persons to maintain their own homes, it was anticipated that some might equate either limited physical strength or limited income as reasons to move from a homestead. No such responses were given. Poor health was the universal condition reported as the occasion of move for parents in both income groups. The arrangements related to this condition are indicated in Table 2 below:

Table 2

Future Housing Arrangements for Parents by Income Group

| | Low-Income | Middle-Income | Totals |
|---|---|---|---|
| Home of Adult Child | 4 | 4 | 8 |
| Nursing home | 1 | 2 | 3 |
| Other* | 2 | 1 | 3 |
| TOTALS | 7 | 7 | 14** |

*Other: Low-income--one respondent indicated that an adult child would move in with parent, one respondent reported that parent would not be moved from own home in the event of poor health, but gave no indication as to how ailing parent would be cared for.

Middle-income--this one respondent indicated all arrangements listed in table as possible options.

**Parents currently in nursing homes are not included in this table.

Comments on Data

Without misusing Chi Square statistics on data generated from twenty interviews, a number of suggestions are evident from the pilot study. Whereas there are no obvious trends in the utilization of other-than-home arrangements by both income groups, elderly parents in failing health tend to utilize long-term care facilities (with two parents in nursing homes in each income group). Even greater use of this and other alternatives is projected for the future. Greater acceptance of housing alternatives may improve the living conditions for frail or seriously ill elderly persons. Consideration must be given, however, to the issue of "my own familiar home" (despite its physical condition) versus improved housing via specially adapted housing facilities for the elderly. No effort was made in the study to determine awareness of various housing alternatives by members of the study sample. More insight is anticipated in the contacts to be made with the elderly parents. A conclusion suggested is that own-home and child's home care for the elderly is less a function of race than of social class which suggests that other alternatives are not only feasible but need to be planned for in future policy decisions.

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# Governmental Influences on Health Care for the Elderly

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## Introduction

This paper describes the public policy transformation of the United States health care services over time. In earlier days the U.S. government provided health services directly to its citizens, whereas today the government provides regulation and reimbursement of health services by the private sector.

Although health care is a commonly used term in the U.S. society, it is a misnomer. Health in its generic sense refers to a holistic perspective of a person's well-being, including the biological, social, and psychological dimensions. However, when health care is referred to in the U.S., it most often means medical care in the traditional sense of diagnosing and treating disease conditions. For the most part, this paper will refer to health care as medical care, because this is how health policy is usually defined. However, during the most recent decade, our society began to adopt a broader definition of health care, one that encompasses a more holistic psychological, social, and physical approach.

U.S. public policy reflects democratically the values and desires of the people as manifested by the laws passed by their elected federal congressmen. Over time there has been a shift in public policy from a paternalistic, direct delivery of services driven by a "right to health" philosophy, to a more competitive, business environment for health services which places more personal responsibility on the individual citizen. This shift from the 1930's to the 1980's follows

Chow's (1987) model of transition in social and health services from Phase I, to Phase IV. In Phase I, care for older persons comes almost entirely from families and relatives. During the early years in the U.S. this practice was the norm since only those who had no families and were poor were served by institutions. Even today it is estimated that 90 percent of care for dependent elderly is provided by family members, mainly spouses or children. The U.S. has passed through Phase II (private or charitable institutions for old people) and is moving from Phase III (public provision of social services to supplement family care) to an awareness of the need for an integrated approach providing support for the elderly including financial assistance and services (Phase IV).

## Public Services Period

Prior to 1930, health services policy was directed to the establishment of a public health system and a veterans health services system. A federal hospital system was constructed consisting of maritime hospitals for seamen, veterans hospitals for disabled veterans, and public health hospitals for people with communicable diseases.

All other services in this period were provided by local government or charitable, non-profit organizations. The health system at this time was relatively simple, consisting of physician care and hospital care with some private duty nursing and visiting nursing services available in the home, particularly in urban areas. All other services were provided by family or neighbors.

## Public Incentives for Health Facilities

In the mid-forties, after World War II came to a close, Congress passed the Hill-Burton Act providing federal matching dollars to build community hospitals and public health clinics. This policy made it possible for small rural, as well as low income urban, areas to have access to hospital and public health services. It also was an initial stimulus for the growth of hospital beds in the U.S.

## Public Reimbursement for Health Services

In the mid-1960's federal health policy first addressed the over-65 year-old age group by providing specialized health programs. Amendments to the U.S. Social Security Act were passed in 1965 establishing the national Medicare Program (an entitlement program or form of national health insurance for the elderly) that paid for physician's services and hospitalization. With the passage of this legislation, U.S. health policy shifted from a philosophy of directly providing health services to becoming a purchaser -- or reimburser of health services for the elderly. The structure of the Medicare policy created problems over time since it provided virtually unlimited reimbursement, particularly to hospitals. This national program stimulated runaway growth in hospital services and accelerated increases in health costs by reimbursing hospitals on a cost-plus basis, with the amount of cost established by the provider. Profits from medicare reimbursement were used by not-for-profit or voluntary hospitals to expand hospital equipment and beds. This expansion of facilities further stimulated cost increases.

By the mid-seventies, for-profit or corporate-model hotel chain hospitals were established to share in the Medicare reimbursement profit windfall. Led by the federal policy for the elderly, private health insurers used reimbursement forms similar to Medicare for all other age groups. Thus the U.S. health system continued uncontrolled growth and spiraling health care costs. Since the health care system did not function competitively, as the system expanded in terms of hospital beds and services, costs did not decline but rather continued to increase.

At the time of the Medicare policy amendment to the Social Security Act, an eligibility program provided a mix of federal and state funds for elderly who were either poor or who had spent all of their personal funds and needed nursing home care. Several influences of this policy need to be pointed out. The Medicaid program was addressed to the less than 5 percent of the elderly population requiring nursing home care. Financial eligibility for this program is so low that only the very poor are eligible. Reimbursement for the Medicaid eligible client is much lower than the rate charged private-pay clients, causing nursing home admisistrators to consider these clients to be less desirable than private-pay clients. Despite the limits of the program, the costs of the Medicaid program to both the Federal government, as well as to the states, have been a burden.

## Cost Containment and New Reimbursement Policies

By the early 1970's it became obvious that the costs of the Medicare program were out of control. Several states received Medicaid waivers to test pilot models directed to limit cost increases. By the late 1970's many states adopted regulatory measures directed to 1) set hospital rates, 2) review hospital budgets, or 3) provide incentives for competition in the health delivery market place.

More regulation at the state level stimulated an increasing awareness that the major emphasis of health care for the elderly was acute care, a focus tht was incompatible with the long-term needs associated with chronic conditions that accompany old age. Yet the policy initiatives of the 1960's which established the National Institutes of Health medical research priorities of heart, cancer, and stroke, led to the development of medical technologies that emphasized dramatic acute care therapies. Fueled by almost unlimited Medicare reimbursement to hospitals, these new acute care technologies became widely available throughout the U.S. Yet for an aging society, health policy priorities provided little other than acute care reimbursement for all persons over 65 years and nursing home reimbursement for the very poor. Because the long-term health maintenance and preventive health care needs of the elderly were not covered, by 1980 the older person's personal out-of-pocket health care costs were at the same level as before Medicare became available.

However, concern with rising costs rather than matching health care services with the health needs of the elderly prevailed with proposed health policy in the early 1980's. The 1982 Omnibus Reconciliation Act restructured Medicare reimbursement based on the discharge diagnosis of the over 65 year old. This system has had a number of dramatic effects on health care for the elderly. There is an emphasis on "quick-fix" medical procedures, primarily surgical, with little incentive to care for the older person who may have more than one medical condition. The prospective payment system shortened the length of hospital stay to the time of medical stability rather than the time of personal adjustment and coping with the condition. Elderly who are discharged from hospitals either go home with home care services, or are discharged to nursing homes for convalescent care. Once admitted to a nursing home, the likelihood for discharge back home is limited. Thus policy revisions of Medicare were not designed to improve services for the older person, but to reduce costs. However, the impact on older clients has been far greater than anticipated. Although these changes in health policy directed to medical care have emphasized acute care services, planners for elderly services have succeeded in introducing community based health services as part of other social services. Two White House Conferences on Aging, one in 1971 and the second in 1981, stimulated the development of amendments to the 1965 American Act. This legislation has placed a greater emphasis on community-based services and preventive measures. Home care, home-delivered meals, and congregate meals with nutrition education, are examples of the shift in emphasis from acute care and institutionalization to health maintenance and preservation of independence. In Florida, public policy has developed a state-wide Community Care for the Elderly program that provides home-based services directed to maintaining older people in their homes. These policies are based on the American cultural belief that all individuals should have the freedom to their choice of lifestyle including the opportuniity to remain in their own home (Committee on Aging, 1986). They also demonstrate a widening of public social services to supplement family care, or Phase III of Chow's model.

## A Changing Population's Need for New Health Care Models

Traditionally, health policy in the U.S. was designed to guarantee the "right to health" for all citizens. The provision of most support services for older persons has been by family, friends and neighbors. An awareness of the impact of personal life style on health status coupled with a concern for allocation of health resources has stimulated a gradual shift in health values to one of self-responsibility for positive health practices by each individual. Competitive health policy is providing additional incentives for individuals, particularly older people, to be active participants in their own personal wellness program as well as when using the health system. Gradually, the values of the general public are reflected in evolving health policy. The current direction in health policy is not favoring more acute care, nor is it providing incentives for increased institutional skilled care. Rather there is a movement toward a blended system of health care that will provide for the total health needs of an individual in the last 20 years of life (Gephardt, 1986). Thus the U.S. is initiating movement toward Phase IV of Chow's model.

Recent trends in health and social services policy are in this direction. There are policy incentives for capitated-payment mechanisms for health services as exemplified by health maintenance organizations (HMO's) and the newly tested social health maintenance organizations (SHMO's). A twofold increase in available home health care services over the last four years is evidence of movement to help older persons to remain in their own homes. The expanded availability of senior continuum-of-care communities reflects a desire for holistic environments where older persons can plan to live out their lives without unnecessary disruption. To ease out-of-pocket costs, proposals for catastrophic health insurance are expected to be a reality soon. And to prevent the spend-down of family estates when nursing home care is needed, long term care insurance is slowly becoming available.

Older people have had more health care needs than younger ones. As the proportion of elderly in our society grows, it is expected that health policy at both the national and state levels will create a health care system that is more compatible with the needs of a maturing society in which chronic conditions prevail.

# The Effect of Government Services on Family Assistance Provided to the Frail Elderly: Research and Implications

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Tradition holds that the family is the first fountain of charity in the United States and that the government must not replace the family as caregiver for the dependent. Under this view, public services must not substitute for family efforts. However, in recent years the boundary between state and family responsibility has shifted. The family remains a key actor in the primary source of care. As public services address needs once met by the family, an efficient public family partnership must be established.

Further, existing intervention efforts must be informed by an understanding of the impact of public services upon family assistance. Do public services replace the family's efforts? Do they support the family? Are there means of ensuring that services will supplement and not displace the family's efforts? Can public services actually increase family involvement?

These questions are especially pressing with respect to the care of the frail elderly. The elderly proportion of the U.S. population has more than tripled this century (to reach 11.2 percent in 1980; Soldo, 1980) and will continue to grow. The losses associated with old age leave many people in need of assistance just as the family members who traditionally provide that help are less available than ever. Public provision for the elderly already absorbs a substantial proportion of the federal budget. Facing population projections for the next sixty years, policy makers turn to the family, advocating that it serve as caregiver of first resort. But the family may lack both the resources and the will to fill this role. Women, the traditional caregivers, have entered the labor force and the few grandchildren there are have left home. Family assistance will not replace public provision for the elderly. In this era of reduced support for social service programs, policy and programs must make effective use of what family support is available. Reform of the long-term care system, one of the most costly public supports for the elderly should integrate formal services with family support. Case management is used in several major reform efforts directed to this end. Does case management ensure a more effective public/private partnership in long-term care?

## The Family's Contribution

The family plays a central role in long-term care of the elderly. The National Center for Health Statistics estimates that as much as 80 percent of the home health services received by the elderly in the U.S. comes from family members (U.S. Department of Health, Education, and Welfare, 1972). The Congressional Budget Office (1977) suggests that the family provides one and one half times the amount of personal care assistance delivered by institutions. In the same vein, Shanas and Maddox (1976) report that two to three times as many elderly are bedfast at home as are living in institutions. A recent report of the Long-term Care Task Force (U.S. Dept. of H.E.W., 1978) suggests that some 3.6 to 7.8 million older people receive services from family and friends. While these figures are necessarily speculative, Callahan (1980) suggests that it is fair to conclude that 60 percent to 85 percent of all disabled or impaired elderly are helped by their families in a significant way.

Families may engage in a wide range of activities on behalf of their elders. Family members often negotiate with the public bureaucracy to obtain needed services (Shanas, 1979). Children frequently help aged parents with home repairs, housework, care during illness, and occasional gifts (Shanas, 1979). When an elder becomes disabled, family members generally provide help with both Activities of Daily Living (ADL, such as getting in and out of a chair or bed, incontinence care, toileting, bathing and feeding) and Instrumental Activities of Daily Living (IADL, such as transportation, housework, laundry, medication management, telephoning, shopping, meal preparation and money management) (Brody et al., 1978).

## The Effect of Services

Given the importance of the family's contribution to the elderly it is important that services complement and not replace, the family's efforts. Research in this area has produced mixed results. In 1965, Peter Townsend examined the relationship between welfare services for the elderly and the family in three industrial nations: Britain, Denmark, and the United States. He observed that institutional, domiciliary health and welfare services tend to reach the elderly who lack close relatives. Townsend concluded that the development of services which attended the growth of the welfare state in these three nations did not broadly conflict with the interests of the family as a social institution. In individual cases he suggests that professional services do not displace the family's efforts, but may refine or extend them (as is the case when home remedies are supplemented with professional medical advice). Townsend suggested that in those cases where services did reduce the family's help on a particular task there may have been a compensating increase in help with another task that went unmeasured.

In their evaluation of the Family Support Program in New York, Frankfather and his colleagues (1981) found no significant substitution of the program's services for family assistance. Most families in his sample of 83 (60 percent) did not report changing their level of support in response to the introduction or expansion of service during a two-year period. Twenty-three percent of the sample did reduce their efforts during the first year, and fifteen percent did so in the second year. The study does not report the magnitude of this reduction. Often this short-range substitution reflected the service provider's desire to provide respite to families contributing a great deal of support in order to ensure long-term support of the elder. Results of this study must be interpreted with caution as they are based upon self-report. In describing their reactions to services families may not be inclined to report that they have reduced their efforts.

Unlike Townsend and Frankfather, Green (1983) found that services can displace the family's efforts. Green surveyed 140 elderly participants in a Community Service System in Arizona. His subjects were long-term care patients in a variety of settings. He used statistical modeling (three-stage least squares) to describe the reciprocal interaction between services provided through the Community Service System and assistance provided by family and friends. His data were based on reports by the patients themselves. He found a substantial substitution effect, suggesting that the delivery of services caused family and friends to reduce their efforts. In some cases this substitution was so large that increased services resulted in a net decline in the amount of assistance available to the elder. However, methodological limitations leave results of this study suspect (see Bond, J., 1984)

Results of a recent study completed by the author (Barusch & Miller, in press) do not support Green's findings. We completed multivariate linear regression analysis of data from interviews with 2,620 low-income elderly in California. A statistical model was developed to predict family assistance with 19 tasks of daily living on the basis of expressed needs, formal services, and family characteristics. Findings indicate that a 10 percent increase in services will result in at most a reduction of 2.8 percent in the family's efforts. Under some circumstances, a "complementary effect" was detected, whereby services actually enhanced family involvement in care.

In a continuation of the previous study, the author developed a system of equations which results in two models. The first describes the impact of personal characteristics, family structure, and life events, as well as public services on family assistance to the elderly. It accounts for 48 percent of the variance in family support. In the traditional (not case-managed) service delivery system the substitution of formal services for family assistance is small. The presence of a case manager eliminates this substitution effect, but is associated with a significant decline (46 percent) in family assistance. Families increase support in response to expressed and objective need. Those who live alone receive less support than others, while those living with a spouse or sibling receive more. Grandchildren and siblings decrease the amount of support available; children increase support.

The second model addresses the role of personal characteristics, family structure and life events as well as family support on service allocation. It explains 18 percent of the variance in service allocation. In a traditional service delivery system services are reduced when family assistance is available. This is not so when a case manager is present. Service allocators respond to increased objective need with more services but, unlike the family decrease their efforts when expressed need rises.

Striking findings of the study include the unresponsiveness of the public service allocators to the eldery's expressed need. This supports Frankfather's (1981) observation that service delivery responds less to consumer preference than to provider preference. The study also identifies individuals who, because of personal characteristics or life events, experience declines in both family assistance and public services. These people are neglected by two significant sources of care. While they may obtain assistance from another source, such as friends and neighbors, they may simply do without. These potentially neglected populations include: elderly men, whites, those living with non-relatives, and those elderly who are forced to change their residence.

## Implications

Research in this area does not support the view that government services completely replace family assistance to the frail elderly. Substitution effects identified tend to be small. Further, the notion that substitution per se is an inefficient use of public services is misleading. The substitution of services for family assistance frees the family member to engage in other activities. He or she may go bowling more frequently, or take more trips to the beauty parlor. In this care substitution results in greater personal consumption. On the other hand, it is also possible that the substitution of services for family assistance in one area is compensated for by increased efforts in another more vital area. Family members may use time they once spent caring for their elders to attend to other responsibilities, such as child care or working. A woman who spends less time helping her elderly mother may devote her newly freed time to caring for her children, or her grandchildren. Where the new activity constitutes a greater contribution to social well-being, services have been efficiently used. Further analysis is needed to determine the total effect of social services on the family. A number of questions merit consideration: Where services reduce an individual family member's contribution, what does that person do with the free time or money? Is it spent on leisure activities and personal consumption, or transferred to other members of the family? Research currently underway at the University of Utah's Long-Term Care Gerontology Center examines this question in some depth. By surveying elderly spouses of terminally ill patients we will determine how they use the time made available through use of respite services.

Whereas the view of services as a substitute for the family has little support, the view that services can serve as an effective adjunct to family care has received some impetus. It is supported by identification of complementary effects in one study (Barusch and Miller, (1986), and clinical observations regarding the effects of respite care. In recognition of the potential role of human service professionals in enhancing family care, it is useful to consider that role in some detail.

## The Professional's Role

As professionals become more active in working with families, we confront a number of difficulties. In contrast to contract providers who are generally available during office hours, family members often prove difficult to locate. Many elderly clients do not know work phone numbers of their adult children. Contacting family members can require efforts extending beyond normal working hours. Further, unlike paid providers, family members are not accountable to the professional. We can not threaten to break off their contract, or withhold payment. We can only cajole. Finally, we may find ourselves in emotionally-charged situations for which we are completely unprepared. In seeking a family member to do yard work for an elderly father, a professional may uncover a history of domestic violence. In view of these and related difficulties, one may wonder why professionals persist in their efforts to work with families.

A number of advantages are associated with higher levels of family involvement in care. The first and most obvious of these is conservation of scarce public resources. Further, the elderly prefer to receive assistance from family members (Bengtson & Treas, 1980). Interventions to improve family involvement in care can also significantly improve the quality of life for a primary caregiver. Zarit and Zarit (1982) compared family interventions with peer support groups for spouses caring for dementia victims. They found family interventions considerably more effective at reducing caregiver burden and enhancing life satisfaction. Finally, Clara Pratt and her colleagues (1985) looked at a wide variety of coping strategies used by caregivers of Alzheimer's patients to find only five successfully reduced the burden of care. Among these was use of the extended family. There is some indication that family involvement in care benefits not only the elderly patient and primary caregiver, but also younger generations, by enabling them to discharge their debt to their elders.

Techniques for intervention with families of the elderly may be divided into three phases: assessment, resource development, and monitoring.

During the assessment phase the professional seeks to understand the nature of social support available to the client. Two approaches can be applied. The first is to use an assessment tool. Using a format such as this, a professional identifies specific activities with which a client needs assistance, then evaluates the availability of family members (or even neighbors and friends) to help. The second, less formal approach to assessment involves use of a "key informant." This individual may be the client, a family member, or even a family friend. He or she advises the professional regarding family history and dynamics, providing information necessary for effective family-centered intervention.

Having identified potential sources of assistance, or resources, the professional moves to utilize those resources in a systematic manner. Zarit and Zarit (1982) among others recommend use of a "family meeting" as a means for marshalling resources. Such a meeting should not be held until the professional has some familiarity with the family. With this knowledge, the professional works with client, primary caregiver and key family members to develop an agenda and objectives for the meeting. It is important that the objectives be specific and measurable, and that the meeting end with specific commitments from participants. For example, a grandson may agree to pick up the client's mail each day, or a son who lives far away may agree to make weekly phone calls to the client. The family meeting, when properly orchestrated offers an efficient means of resource development.

Once the professional enters the monitoring stage of this process he or she is involved in regular contacts with family members and periodic adjustments in the care plan. By this time the professional's role has changed. He or she no longer serves an individual. The client is the family. The professional's knowledge of group dynamics and interpersonal skills (warmth, empathy, ability to communicate) will prove critical to the success of this intervention.

## Summary

Recent research indicates that services do not simply replace the family as caregiver for the frail elderly. In fact, the relationship between services and family care is too complex to be described in terms of substitution. In some situations services can enhance family involvement in care. The human service professional, as a link between government services and the family, is uniquely qualified to ensure that services do support family care. Continued improvement of family intervention techniques, such as these presented here, will enhance the professional's ability and willingness to fill this critical role.

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## The Federal Government Perspective

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Since 1900, the aged in America have grown from 3 million, or 4 percent of the population, to 28 million, or 12 percent of the national population. The aged over 65 represent 18 percent of Florida's population. These latest numbers will double again over the next three decades. The graying of the nation has resulted in important federal legislation being passed since the 1935 benchmark of the Social Security Act. This paper will review the major federal advances in elderly legislation with a summary explanation of how federal policy is made and a delineation of the roles of Congress and the administration.

The Social Security Act of 1935 is viewed as the most important piece of domestic legislation in 200 years of U.S. history by those who view the federal government as being ultimately responsible for the children, elderly, and disabled who cannot take care of themselves. When Congress passed Social Security they did not envision it would be 21 percent of the federal budget in 1983. The intent was that it would be a contributory system with all costs paid by employees and employers, so that it would not be affected by future changes in the political environment. Social security payments are viewed by many as the greatest economic stabilizer in the United States' panapoly of programs and have lessened the impact of economic recessions since 1939. Winston Churchill has been quoted as saying: "Social security brings the magic of averages to the needs of millions of old and disabled, and that it has to be compulsory because it is a commitment to the old and young, black and white, well and sick.

The affluence of the late fifties and sixties resulted in the expansion of the mid-sixties federal legislation and related growth in responsibility and commitment to the elderly. Thirty years after the passage of the Social Security Act, 1965 was a watershed year with the passage of elderly and indigent health care financing legislation through the Medicare and Medicaid Acts. Social Security coverage was broadened, the Older Americans Act was passed, and the first White House Conference on Aging was held in the nation's capitol. In the late sixties, the Age Discrimination Act was passed and funding was increased for the elderly programs approved earlier.

The organizational structures for implementing aging related legislaton were addressed in the seventies with the establishment of a national network on aging under an exanded Older Americans Act. Legislative committees on aging were established at the congressional level and the National Institute on Aging was created. The Supplemental Security Income (SSI) legislation was passed to provide a minimum guaranteed income to poor elderly, blind and disabled persons.

According to Robert Binstock, the sixties and seventies federal legislation for the elderly was a broad, symbolic response to the needs of a growing, aging population. The federal laws were general rather than specific in explaining the federal government's responsibility toward the aged; and there were relatively small amounts of funding allocated to implement the legislation. Furthermore, the creation of the state and local aging network to implement the programs and to deal with the conflicts over inadequate funding may be viewed as the precursor to the federal budget cutting strategies of the eighties.

The current federal commitment to aging programs and continuation, much less increased, funding is undergoing great scrutiny. The 1983 delay of the cost of living increase in the Social Security payments was the first major downward change of the system in fifty years. Since the substantive allocations never equalled the commitment of the federal legislation of the sixties and seventies, and given the current cautious mood at the federal level, there is a concern among states that the federal responsibilities and commitment for the growing aged population are being given to the states.

The problems associated with an entity taking responsibility for the elderly will only become more acute. It is a reasonable assumption that the number of frail elderly requiring assistance will grow by 70 percent over the next fifteen years with an increase of $12 billion in just long term care (Brecher and Knickman, 1985, p. 245). The hard decisions of who is responsible for and who will make the funding commitment for the aged will not be left at the federal level. It is increasingly a shared responsibility with the states and the family.

## The State Government Perspective

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Until the mid-seventies, the major policy gains of the elderly were administered through the federal programs of Social Security, Medicare, public housing and Old Age Assistance and bypassed state agencies. However, with the decreasing federal resources, there has been an increasing responsibility placed on state and local governments. The federal perspective differs in stating that it is lessening regulatory requirements to give states more flexibility in providing services to the aged. Given a fast growing elderly population and reduced federal funds, the state becomes responsible for what may become an empty entitlement to care.

Therefore, the state's perspective is becoming increasingly one of being given more responsibility for an aged population with limited federal funds. It is an uneven partnership among the states and the federal government. Florida is seventh in its tax payments to the federal governments and is 46th in the receipt of federal funds. It has the highest proportion of elderly amongst the states. There is concern that the current emphasis on decreasing the federal deficit will lead to devastating cut backs in the Older Americans Act, Medicare and the over 80 other aging related federally funded programs. The increased design for governmental austerity will push the major responsibility and commitment to the state and local governments for the aged for recent studies indicate the family responsibility is at its pinnacle. Increases in life span, aging of the elderly, and substantial increases in medical care costs accompanied by a declining purchasing power of retirees are cited as factors which will impact the fiscal responsibility of state and local governments.

Florida funds community-based social, institutional and health related supportive services through a variety of programs including the Older Americans Act, the Social Services Block Grant, Medicaid and the state funded Community Care for the Elderly Program. The aging services network consists of direct service counselors and contract providers, primarily administrated by the Area Agencies on Aging contract providers.

The Community Care for the Elderly Program was established in 1977 to develop institutional alternatives for frail elderly. The $30 million program is coordinated with Older Americans Act Programs at the local level to provide "core" services considered supportive to maintaining persons in their own homes. The major services are in-home meals, personal care, homemaker, chore, transportation and adult day care. Although there are no income requirements, the targeting to the frail, home-bound elderly results in 78 percent of the recipients having income close to the poverty level. The average client care service cost is $100 per month.

The Home Care for the Elderly program is a state funded family subsidy that averages $122 per month for functionally dependent persons living with a caregiver such as a spouse or child. The average age is 83 and 70 percent of the HCE clients have income below $343 per month. HCE clients are, on the average, the most impaired of any clients served by the State. This is due not only to the prioritization process but also to the fact that anyone needing the 24 hour supervision which caregivers provide is likely to be severely impaired. The presence of these family supports allows persons who would otherwise require insitutionalization to remain in the community.

Medicaid is a joint state-federal program designed to provide health care to the poor. It is the U.S. major public funding source for long term care. A person has to "spend-down" his or her assets and have limited income to be eligible for the Medicaid supported nursing home care. Some call this the "federal impoverishment requirement." Medicaid is one of the largest single programs funded by the States and is also the fastest growing single budget line item. A major reason for this increase is the growth in nursing home care. In 1985, over $400 million in Medicaid funds (45 percent of the total Medicaid budget) were spent on the older persons in nursing homes in Florida, who comprised less than 25 percent of the State's Medicaid caseload. By the year 2000, this expediture will exceed $1.9 billion in Florida.

On a per capita basis, over $3,100 a year is spent on health care of older persons. The older person paid $1 in medical costs for every $7 of income in 1986 and by 1989 it is estimated they will pay one dollar in medical costs for every $5.50 in income. The cost of health care for this group - including doctors, hospitals, medicines, and insurance premiums - increased at an annual rate of 14 percent from 1980 to 1984 while personal income for older persons grew an average 8 percent a year. This year older persons are expected to spend more of their income on health care than at any time since the Medicare and Medicaid programs began in 1966. These trends indicate that the burden of health care costs for older people is likely to fall more heavily on the states in the years ahead and require innovative means of controlling health costs without reducing the quality of health care or access to it.

Therefore states are increasingly faced with the triple bind of increasing elderly medical and long-term care costs with the aging population increase, declining revenues and strong resistance to tax increases. The results are mixed across the states. New York funds over 3/4 of the national home care for the elderly services and meets approximately 50 percent of that state's need. Florida's Home Care for the Elderly Program meets between 3-6 percent of the projected need in the state. Some states are experimenting with a deregulation of nursing home bed construction. The intent is to reduce administrative and legal costs in the state's regulatory role while studying the impact of a free market development approach. Aligned with this are the efforts of many states to involve private insurance companies in long-term care insurance.

Given Florida's rapidly changing demographics, Florida has the opportunity to provide a model for caring for an aging population. A large population that retired during their 60's are now growing into their less active 70's and on to their eventual 80's. The increasing population of individuals sixty, seventy, eighty and older need appropriate housing. The health and social service needs of these individuals change as their age increases. There are a variety of options which may best provide for the needs of an individual. No one of these options is best suited to all individuals. Although these services are available in some areas of Florida, there is a general shortage of services in most areas. Rental assistance and public housing programs have long waiting lists and limited resources; therefore, they are forced to limit the enrollment of their programs. The number of elderly individuals in need of existing services is increasing. The effects of the new federalism on states, such as Florida with a high growth rate of seniors, is anticipated to be a continuing reducton in federal funds. In addition, the problem of a fragmented service continuum remains. The State of Florida is working to fill in the gaps of the continuum. Increased taxes will probably be the the only recourse to generate funds to cover the costs of gap-filling services.

However, foremost among the changes noted in elderly care service delivery, is the impact of federal cost containment strategies on state and local governments as well as providers and recipients of care. DRGs (Diagnostic Related Groupings for hospital reimbursement) for instance, have lowered per capita expenses for hospital care, while increasing the demand for home health care and in-home social services such as personal care and homemaker assistance. Growth in the aging population and the federal government's strategic reimbursement policies to reduce hospital costs are influencing the development of new markets and the merging of health and social services into comprehensive long-term care programs. There is increasing evidence of private sector development, particularly in home health care. The proliferation of health maintenance organizations, various kinds of supervised care, congregate living arrangements, home health options, case management long-term care insurance, and other forms of community-based care not only adds to the fragmetation already evident in the system, but confuses the prospective older consumer who often selects care arrangements without professional assistance.

As we view the immediate and distant future, we see the need for extended government efforts to coordinate services and unravel the confusion experienced by older persons and their families who are seeking assistance. The first element of the Florida's aging services plan is to ensure access to available community based and institutional services, and the second in the coordination of those services. Access and coordination are the fundamental building blocks of the State government's Community Service System program now in its implementation phase.

# Learning Needs of Older Adults

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In June, 1984, Governor Bob Graham appointed the Florida Committee on Aging to research, review, and make recommendations regarding the many aspects and concerns of aging. The document produced by this committee, "Pathways to the Future," is an important resource for government, business, private individuals and groups involving suggested policies and strategies in serving the older population.

A primary issue addressed was the concern for post-secondary education for and about the older adult. Older nontraditional students represent a significant market for all types of educational institutions. Any institution that seeks to attract and serve older learners must be clear in its mission, philosophies, and purposes to make them compatible with the services required for the older learner. It must give out the message "You are never too old to learn" and act like it wants to serve this population.

Some of the major barriers that prohibit older adults from returning to college are money, time, information, and fear of failure. These barriers can be removed if institutions examine carefully their institutional policies, guidance and counseling services, career development programs, diagnostic test offerings and administration and staff attitudes toward the older learner. Institutions which have successfully incorporated the adult learner have carefully studied the relevant demographic and psychographic data, programs, policies, and procedures and made changes when necessary.

Possibly more importantly, the difference in motivation for learning is one of the major issues to be addressed. Unlike children -- and in many cases participants in professional training -- the older learners have already acquired a certain amount of knowledge during their lives. Their goal often is not to improve financial standing, nor are they seeking any form of power. Their objective in education is often altogether different -- not a preparation for working life, but a search for personal fulfillment. Consequently, the programs of learning cannot be limited to academic studies but geared to the total range of human experience.

To serve this population, educators must modify the traditional idea of education as conceived by industrial society -- preparation for job. Education is perceived as an advance of credit to the young and active whose skills will be called upon as repayment in offices and factories. The older adult becoming involved in education turns the value system upside down and puts in place alongside the official "productivist" ethic a "personalist" education ethic which could include other segments of the culture. This is returning to the first principles of education, when education was viewed as adding to the quality of life.

New educational structures are emerging. Older adults are regaining an educational role in their community and taking the place to which they are entitled in society. This contributes to the rebirth of cultural involvement. Being better integrated into society and more in tune with the world, even though professional and occupational roles have been fulfilled, they are able to perform social and political roles and give a new sense of community because they are the ones with time, experience, and dedication. The educated older adult becomes an agent of social change, with a more effective role the better educated he/she is. This will transform the stagnation of old age into the possibility of success and add credence to the saying "To grow old is to live."

But it must be emphasized that this is not investing in knowledge by the older adult in order to cash in on a higher position, more prestigious possessions or more kinds of personal power, but to give new meaning to years of older adulthood and meaningful status for older adults. Education could assist in breaking the isolation of older persons, promoting social reintegration, and permitting them to participate more full in society, thus improving the relationships between generations and in consequence promote more human balance. In societies centered on production and scientific management, it is important -- in order to form sound judgement of the effects of technical civilization -- to take into account a cultural thirst which is manifested in diverse elements of the population. To integrate this special population into our educational institutions could involve a radical revision of pedagogical thought that would contribute to the discovery of solutions to the crisis in education that often faces industrial/technological society.

These students bring with them the unusual quality which can create a natural association between joy of learning and joy of teaching. Lectures can be dialogues and debates, courses opportunities for exchange; and often the separation between teacher and learner found in a formal educational structure is lessened. This is truly an indicator of a potential learning society.

Some of the questions to be answered have been presented in the Postsecondary Education Planning Commission of Florida. Questions to be addressed in the future are:

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| WHY? | What educational needs should be the focus of concern? What priorities should be given to lifecoping and survival skills? Is there room for personal enrichment and mental stimulation? What about second careers, and/or successful adjustment to aging? Should there be training in self-help and advocacy? What outcomes should be sought? |
| WHO? | Who should be educated? Should educational programs for older adults be supported by public funds? Should these publicly supported programs serve only disadvantaged? The uneducated? The undereducated? What about other senior populations? Should there be specialized programs for older adults adults or should these programs be incorporated into existing programs offered the general public? |
| WHAT? | What should be taught? What do older adults want? What do they need? What content areas should be the focus of attention? What problems should be addressed through learning opportunities? Is preretirement education needed? Is it wanted? When should such education take place? Should special programs be developed for the increasing numbers of "new" residents in Florida? |
| HOW? | How should education be provided for older adults? What should be the role of existing instruction and agencies? Should special provisions be made to encourage the participation of older adults? How can access to education be improved? What are the physical or other barriers to education that need to be taken into account as programs are planned and implemented? Should educational programs be offered primarily in formal educational settings? |
| BY WHOM? | Who should teach older adults? What should be the role of older adults? How should they be involved in planning educational activities and programs? How should they be involved in implementing these activities and programs? |
| WHEN? | What about the young, middle-aged learners? Do they need to learn something about aging and the aged? Where should this be done? |

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# Health Care Marketers Should Map Strategies

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I am not an academic person by profession, although I have done a little teaching. My background is in business, and I have been involved in marketing as a discipline for over 25 years. For the last six years I have had my own business, and we concentrate on health care marketing and marketing research in the United States.

Basically, I want to just make three points. The first has pretty well already been made, that health care for older people is now a significant market in the United States. In the past there was scant attention paid to the elderly. Warren French has outlined that the elderly are generally sterotyped as a small group of people who don't have a lot of money. No one has been terribly concerned about them from a marketing perspective. As has already been documented, the elderly make up a very large, growing group in the United States, as well as here in the Republic of China. I think the important thing is not just the percentage growth, but the absolute size of this group. Researchers tell us that by the year 2000 there will be 35 million people in the United States over the age of 65 and 5 million over the age of 85. And that's a large market.

Also, as Stanley Wallach has said, it's a market that requires looking at in a new perspective. The basic model for dealing with health care in the United States is based on acute health care. The needs of the elderly are different. We're looking at chronic care versus acute care, care that's going to continue for a long period of time. We're also dealing with people over a span of time. Instead of seeing a patient, treating them, and having the patient recover and go on their way, there are people that the provider must deal with over a period of years, perhaps as long as the provider's life. Last of all, our health care providers have been trained to make people better and to feel satisfaction in their patient's recovery. Today the chronic patient does not get better and actually declines in health. That's a natural phenomenon, but it's one the provider often has difficulty in dealing with from their own emotional feelings.

This is not just a health care problem. These are patients whose care involves not only their medical well-being, but their housing, their transportation, and their social environment. So it's a much broader type of issue than we've dealt with in health care in the past. It is also a segment that, in our country, has a large and growing regulatory involvement. Since the government is paying the bill, the government is calling the tune. We have now a system, the DRG's, where more and more the government is mandating what the care is, how long it should last, how much will be paid, and how much the providers themselves are going to receive for this care.

But, as French has mentioned, the old sterotypes are being shattered. We're not just dealing with ill people, we're not just dealing with people with limited resources, and we're not just dealing with people who are satisfied with perhaps a low quality level of care. We're now dealing with people who are more interested and involved in their health and their health care. An issue that hasn't been touched on much at all, but one I think is very important, is the change from the provider being responsible for the patient's care to the patient himself or herself being responsible for their well-being.

That is, the person who is the patient having the responsibility for getting better or for taking care of their own health care. We have tended to focus on putting the responsibility on the provider -- the nurse or the doctor -- tells you what to do, gives you pills, tells you to stay in bed, tells you when to get up, tells you when to go to the bathroom, tells you all these things, and you're there following orders. That is not the way things are happening now. The patient is saying, "Wait a minute. I want to understand what's happening. I want you to explain my problem to me. I want to know why you're giving me these things." And the natural outgrowth of this, and a very healthy one, is that the patient has a responsibility to get better and do something themselves. And if you consider this in the context of the chronic health problems, it's very important, because many of these problems are caused by responsibilities people haven't taken; they have abused their bodies through smoking, drinking, gaining too much weight and their general lifestyle. An interesting article in the New York Times recently is about a system of care for the elderly in Denmark and the focal point is self-determination. That is, the patient determines the kind and amount of care that they are to receive.

Now, what is the role of marketing in all this? "What is this guy talking about marketing doing up here?" First of all, let me give you a very simple definition of marketing. Basically marketing is involved in two things. Number one, identifying who are the customers, as we say in marketing. In other words, who are we trying to serve. And then learning as much as possible about them; what are their needs and attitudes. Once we learn who the customers are and what their needs and attitudes are, then we can develop a service or a product to meet these needs. Then it becomes very easy to sell someone something that they need.

So the first and most important job of marketing is to identify the customers and to identify the customers needs and wants. From this perspective, it is my viewpoint, that we're moving away from the era when social service people can develop programs for other people. In the past, we have had social service professionals develop these wonderful programs, and tell their clients, "It's for you, the client. It's a terrific program. You ought to be really grateful and happy that we've developed this program for you." Today the programs, if they are to be successful, must be designed from the client's perspective, not that of the social service worker. As Wallach has pointed out, we need to understand what the clients want, what their needs are and what their attitudes are toward social service programs. Roland Follenshed has raised the issue of what the interrelationship is between the caregiver and the care receiver -- how the caregiver's attitudes shape how the care receiver is treated and what kind of care he or she receives. He talked about applying for food stamps and all of the kinds of dehumanizing things people must go through to get a service that is supposed to be available to help them. His point was that in the delivery of this service, the caregivers made the product very unattractive by the way they treated people. So we have to understand the customer's attitudes toward the social service programs and such programs must be structured to be usable by the customer. You can have a wonderful program but if there's no way for the user to really get to it, perhaps because they don't have transportation, etc., it won't be a very well-utilized program.

Also, as Professor Wallach has mentioned, we have to measure the potential demand for programs so that resources can be allocated to those areas where there is greatest need, so that limited resources can do the most good. I would suggest, therefore, that an important activity that is needed and will grow is market research to determine what the needs and attitudes of the elderly are.

Another point I want to make, and again, I've been fortunate because it's been set up for me, is the importance of having a marketing complement in your social service program. I believe there are more programs in the United States than people are actually aware of, use, and sometimes need. The real problem is to bridge the gap between the program and the users, so that the users are aware of the program, know about the program, and indeed make use of the program. I also think you must also be aware that you are in for a lot of competition, because as this market grows, it is attracting many people to it from the outside. For example, the Marriott Hotel Corporation in the United States is going into life care business. They have three centers under construction now and they say they may build as many as 400. The life care people were previously church organizations. Hospital Corporation of America is the largest multihospital chain in the United States. They are now starting a program called Serving Seniors aimed at attracting senior citizens to their hospitals. Sears and Roebuck, which is the largest retailer in the United States, now has a program called the Mature Outlook Club. They have decided that senior citizens are desirable customers and

Sears wants to have special programs to attract them. So my message to you is that if you don't have a marketing component in your program, you're going to find these new competitors coming into the marketplace and they're going to outmarket you; they're going to attract many of the desirable customers and they may well leave you with the customers who are less able to use your program and less able to pay for it.

My last point along these lines is that you have to reorient your thinking. In the past in the social service area, the attitude has been, "How can we develop a program that costs as little as possible, a bare bones type of thing, trying to keep our costs down?" That's certainly desirable, but I think in terms of the marketplace, that doesn't always work. Instead, I suggest that you think in terms of what is the highest quality program we can have, that is the most acceptable to potential users. That is the program that I think will be the one that is the winner, that will have the greatest acceptance. And if it is a successful program with high public awareness, that's the kind of program that will be supported by the public and by the government. One last observation I want to make is that these 35 million people over the age of 65 are also voters. I think a lot of the issues that were raised about how we are going to finance assistance for the elderly are going to be settled at the polls, because these elderly voters are going to make it their business to get these programs financed.

# The Market Behavior of Senior Citizens

**Warren French**
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For thirty years, marketers have stood behind a twofold concept. This concept, while expressed in simple terms, summarizes the operational philosophy of marketers -- to the point that it has been given the label of the discipline. It is called the marketing concept. Concisely stated, the marketing concept proclaims that the purpose of business is:

"Consumer satisfaction at a profit."

The marketing concept, at first reflection, seems both admirable and reasonable. Marketers work enthusiastically with the incentive of profit, and consumers obviously seek satisfaction from their purchases. The viability of the marketing concept, though, depends on how well its two parts mesh. If one of the two parts, either consumer satisfaction or profit, dominates the market transaction the economic system of exchange may lose its efficiency. In pragmatic terms the concept depends on balance. The notion of balance should not be alien to marketing activity in any culture. The need for balance in Western civilization can be traced back to Aristotle who advocated moderation in all activities. In the East, balance between yin and yang is premised as a means to attain a desired state of harmony.

Is this notion of balance possible in marketing transactions when the consumers to be satisfied are elderly? The needs of senior citizens seem evident, but do marketers judge this group capable of generating enough business to constitute a separate market, let alone separate markets? For a group to be worth attention marketers usually look for three characteristics:

1) It must be large enough and profitable enough to merit cultivation.
2) There must be information available about the group's particular buying behavior.
3) The group must be accessible to promotional campaigns.[1]

We in marketing have only faced up to the fact in the last decade that senior citizens have exhibited the first characteristic, potential profitability. We are still in the initial stages of our research to see if the other two characteristics are present.

It is these latter two characteristics -- particular buying behavior and promotional accessibility -- that have been the focus of the research which a team at my institutes has worked on over the last eleven years. The results of that research and the implications for marketers (starting with a brief description of potential market worth) are capsuled in the following comments.

### Characteristic 1: Size and Profitability

To justify research into senor citizen's buying behavior and their methods of obtaining product information, there first must be proof that the elderly are a market worth pursuing. The percentage of people 65 and over in the United States now stands over 11 percent. That number will rise to 20 percent by the turn of the century.[2] While this trend has caught the eye of American marketers, its counterpart in other countries has not attracted as much attention. In countries where the average age of the populace has remained stable or decreased, government and businesses have paid more attention to the economic problems of youth as they grow into early adulthood. Yet, even in these countries the absolute number of people surviving past middle adulthood is increasing.

Increasing population numbers should project into increased sales. This projection has been a problem for American marketers. While it may be true that less than 15 percent of senior citizens are below the poverty line in the U.S.,[3] another third of that group are just above that line.[4] While some countries in northern Europe can show more affluence than depicted by the preceding numbers, most countries have conditions which show less than desirable economic circumstances for the elderly. What results is a very discerning group of older people who carefully weigh the price/value offerings of marketers. This is a difficult audience for marketers to win over. A market segment which carefully husbands its discretionary income causes marketers to pause before deciding whether it is worth pursuing. Part of this pause is caused by some folklore relating to senior citizens' buying behavior, e.g.,

- they don't purchase new clothes,
- they don't purchase new household furnishings,
- they won't try new brands unless those brands are much cheaper than the items which they now purchase,
- they rely on experience rather than believe in advertising when deciding on what to purchase,
- they resent ads that are aimed directly at them, and
- they should be considered as one rather than many market segments.

This folklore gave impetus to the series of studies which we have undertaken with respect to buying behavior and information gathering.

### Characteristic 2: Particular Buying Behavior

Buying behavior is usually a reflection of social and psychological as well as economic needs. Thus, analyzing the attitudes, interests and activities of the elderly as well as their economic circumstances might indicate future needs which marketers could attempt to satisfy. Past research, however, has shown that there is more variation in the needs and purchase behavior of senior citizens than there is within any other life cycle age group.[5] This coincides with Neugarten's findings that the behavior of senior citizens should be analyzed more according to how old they are versus being grouped as a whole.[6] Yet, marketers, with few exceptions[7,8,9], tend to view senior citizens as comprising one market.

Two studies by gerontologists caused our research team to doubt the notion that senior citizens should be treated as one homogeneous market. The first study, by gerontologists at the University of California, identified five distinct mannerisms of behavior in senior citizens.[10] The second study, by University of Chicago gerontologists using a larger sample, identified eight such behavioral mannerisms.[11]

#### Research Effort 1

Our research team synthesized the California-Berkeley and Chicago (Kansas City) study categorizations of behavioral mannerisms into two broad classifications labeled "active" and "passive". A sample of senior citizens within the geographic areas neighboring our institution agreed to participate in our study. In the initial phase of the study people placed themselves into one of the two synthesized classifications. A number of significant differences appeared between the two groups in how they reacted to marketing stimuli -- differences which did not appear when the sample's answers were analyzed by age (young-old versus old-old) alone. Among those differences were the "actives", strong desire for variety in the choice of products and the "passives", focus on price appeals.[12] This set of results led us to our second research study.

## Research Effort 2

With an instrument containing the mannerisms identified in the Berkeley and Kansas City studies, we approached a national sample of gerontologists. The sample was asked how prevalent each mannerism was and how senior citizens who displayed these mannerisms could be approached without insulting them. (See Table 1) What became evident from the comments of 200 gerontologists was the difficulty to be encountered when marketers approached elderly consumers to satisfy their needs.[13] What also became clear was the absurdity of any marketer trying to appeal to all mannerism groups as if they were a homogeneous whole. Reinforced by the concept that senior citizens had to be approached as a set of heterogeneous submarkets we embarked on our next research study.

## Research Effort 3

Both Berkeley and Kansas City studies used clinical psychologists to assess the personalities of their sample group members. This type of assessment is not the normal research procedure implemented by marketers. Furthermore, future marketing research to predict and meet the needs of senior citizens is unlikely to include clinical assessments of the target group's personalities. Yet, personality shouldn't be dismissed as an influencing factor in elderly consumers' behavior because it is difficult and costly to measure. The research procedure arrived at in our study was to administer Jackson's Personality Research Form E as part of the instrument to identify behavioral mannerisms. Testimonials for the form rated it as an acceptable tool to be used for an elderly sample.

In addition to the Jackson Personality Form, a life satisfaction scale and a activity index were included in the research instrument. These three dimensions of elderly consumers are the same dimensions which were the crux of the University of Chicago's Kansas City study. Over 300 senior citizens in two states participated in our study. The mannerisms gauged by the three dimensions closely mirrored those found in the Kansas City study.

These behavioral types were then matched against attitudes about and behavior in the marketplace. (See Table 2) The results showed some significant differences among the mannerism groups with respect to market behavior. The two market related issues that capture the most attention are differences related to bargain purchases and to trying new products.[14] These results belie some of the folklore concerning elderly consumers mentioned earlier.

## Research Effort 2 Revisited

The third phase of our research led us to believe that the behavioral mannerisms which people exhibit when adjusting to old age are real and just not an artifact of the research environments of Kansas City and Berkeley in the 1960s. But, eight or nine behavioral groups may represent more submarkets than marketers may wish to individually appeal to. We were interested in common threads that might run between two or more of those submarkets. Those threads could allow marketers to aggregate groups to the point of creating a set of target marketers which could be appealed to profitability.

We returned to data gathered from gerontologists in the second phase of our study. Part of that data base, which had been left unanalyzed, was examined with the goal of isolating market related behavior. The part that had been analyzed before was reviewed with the goal of creating sets of subgroups that could represent target markets. This reanalysis produced the following results. (See Tables 3 and 4).

## Research Effort 4

The next phase of research was geared to marketing goals and the practical limitations of data gathering. Behavioral mannerisms are based on more than perosnality. They reflect a style of life that has other dimensions. Marketers are interested in submarkets which are as completely defined as possible. Data bases exist that include demographic, economic and life style information. Armed with the information from our previous research that behavioral groups do exist, we approached market segmentation with a broader perspective. We obtained access to a nationwide consumer panel which contained complete profiles of 150 senior citizens. Also included were data on the sample's purchase behavior.

Clustering techniques were applied to the sample's profile data in an effort to arrive at possible market segments. Five such segments were identified and verified by two separate clustering methods applied separately to one year's sample profile and then to a second year's sample profile.[15] (See Table 5.) These groups closely paralled groups found in both the Kansas City study and in our phase three research study of 300 senior citizens in two states.

What was becoming evident to us was the existence of identifiable submarkets which were not only consistent over time but consistent between independent studies in different locations using different measurement instruments. Matching the results of our latest research to the clusters produced in our previous study produced a problem of where to draw the line in isolating a viable number of submarkets. It appears that the Focused and Reorganizers can be grouped together as submarket with particular behavior patterns and, by the way, with the most spending power available for discretionary purchases. Likewise, the Apathetic, Angry and Self-Blamers can be grouped together. However, the cluster's less than ideal adjustment to old age presents a set of problems which are not in the domain of marketers to solve. Also, put in more blunt terms, this is the least affluent of all the groups and they have little money available for purchases other than the necessities of life.

Before making decisions about how many separate submarkets should be isolated among senior citizens, another factor must be considered. It was previously stated that marketers look for three characteristics relating to size/profitability and particular behavior have been identified. What has still to be established is whether it is possible to reach senior citizen target markets with specific appeals.

## Characteristic 3: Accessibility

There is apprehension among marketers that senior citizens take affront to ads directed solely toward them.[16] A tangent research study which we conducted among senior citizens in four countries on three continents revealed that this apprehension is well founded.[17] This reaction translates to a question among marketers as to whether senior citizens expose themselves to ads and, if so, do they believe them. To answer this question, our research approach to the topic of product information gathering directly as well as indirectly. In addition to items related to product information gathering contained in our four previously mentioned research efforts we conducted a fifth study totally dedicated to the topic. The findings from those studies are as follows.

### Research Effort 1 Revisted

Our first study had split the sample into two groups -- actives and passives -- based on the mannerisms which they had adopted when adjusting to retirement. The use of media by both groups did not vary much, but their notice of and reaction to advertisements in those media were dramatically different. Both groups watched television to a significantly greater extent than they read newspapers or listened to radio.

These quarters of the actives, though, thought that ads are generally truthful. Less than half of the passives agreed with that opinion. Actives also stated that ads are an important source of information to them and that ads actually influenced their choice of stores to shop in. The passives, in contrast, disagreed with each of those observations. These differences are reinforced by the advertising recall patterns of both groups. The actives tended to remember ads directed to older people to a much greater degree than did the passives.

## Research Effort 2 Revisited Again

The sample of gerontologists questioned in our second study had a set of opinions relating to how the subsegments can be reached. The Succorance Seekers and the Constricted were grouped by our clustering procedures into one market segment. These two groups are the only ones that are easily persuaded by the opinions of others. But, it is personal contact rather than media advertising that works best in winning them to a point of view. The other groups are also hard to win over. The cynicism of the Apathetic, Angry and Self-Blaming groups, for instance, makes them almost impossible to reach. There are, though, recommended ways of approaching them (See Table 6).

## Research Effort 3 Revisited

While the preceding suggestions for appealing to elderly subgroups came from gerontologists, as much attention should be paid to what senior citizens, themselves, think about the information gathering process. Using the same five clusters identified in Research Effort 2 the following recommendations can be projected from Research Effort 3.

Cluster 1: Both the Reorganizers and the Focused are receptive to ads showing active senior citizens. See Table 7. The Reorganizers appreciate involvement appeals while the Focused are sympathetic to messages stressing friendship.

Cluster 2: Succorance Seekers, while grouped with the Constricted, have somewhat different buying motives. The Succorance Seekers are more concerned with status while the Constricted focus on health.

Cluster 3: This submarket is probably the least affluent of the five. The group members don't spend much time shopping, but the products which they purchase vary significantly. The Apathetic prefer low priced goods while the Disorganized look for well advertised brand name.

Cluster 4: The Holding On group is particularly sensitive to negative old age stereotypes. Respect and self esteem are highly important to them.

Cluster 5: The Disengaged are difficult to reach. They are not swayed by emotional appeals and show little inclination to buy more than functional products.

## Research Effort 4 Revisited

We also aggregated the panel survey groups into the clusters arrived at in our second research effort. (See Table 8). While five clusters appeared after the analysis, further aggregation could have reduced the groups to two intuititive clusters. Roughly labeled, these two clusters would be similar to the two aggregate groups used in our first research effort -- actives and passives. The actives would include the Reorganizers, the Succorance Seekers and the Constricted. The passives would be comprised of the Apathetic/Angry and the Disengaged. Of these two aggregate clusters, the passives would be, by far, the most difficult for marketers to reach.

Research Effort 5

Our last effort employed the same investigative instrument as used in the fourth study. Over 200 senior citizens, part of the Market Facts Consumer Panel, were the sample for the study. The classification method used for this sample, however, was different than that used in our previous work. Four statements relating to information seeking and advertising receptivity formed the basis of our clustering procedure. The clusters (validated over two years) were then matched against media usage.

Previous research on the elderly's search for and use of information relating to products has appeared in the gerontological, journalism and marketing literature. Almost all of these studies have aggregated the elderly into one group and have drawn conclusions about senior citizens in general. We reviewed over twenty of those studies and came away with the following impressions as marketers. Television advertising is the most effective type of media promotion to elderly. Print advertising, with the exception of magazines directed to an elderly audience, is generally not productive.

Our clustering procedure results in three subgroups with different reactions toward and use of media for information gathering about products. Again, our results bring to question research studies in marketing which have treated senior citizens as a homogenous market. The three segments which we identified have different outlooks on media advertising. (See Table 9). Two of the segments are skeptical about advertising but the third group matches the folklore sterotype which completely distrusts advertising.

## Conclusions

This fifth research effort has brought us to the point where we are now. Our work so far has accomplished only one objective. It presents a case to marketers that there is more than one, viable, market segment among the elderly. While we have left a number of loose ends untied, e.g., matching behavioral clusters to information usage clusters, there are some conclusions we feel confident in marking.

Creating clustered sterotypes in any behavioral discipline is a risky venture. There will inevitably be overlaps between stereotypes, evolution from one type to another, as well as behavior which doesn't fit into any set classification. Yet, in marketing to senior citizens it makes sense to group senior citizens according to factors which are of interest to marketers rather than treating them as a homogeneous whole. This grouping procedure, while possibly subject to misuse, has its roots in gerontology.

Studies by Neugarten, Havighurst & Tobin and Richard, Livson, & Petersen, among others have empirically identified distinguisable mannerisms which the elderly adopt in adjusting to old age. Our research efforts resulted in mannerisms which are suprisingly similar to those found by the gerontologists. Determining successful approaches to these clustered individuals can provide a basis for marketers to meet their needs as consumers. There is, admittedly, the possibility of exploitaton. Yet, we had better reflect back on the starting point of this discussion -- the balance that is needed between the two parts of the marketing concept. Not only must profit be the goal of marketers, but a satisfied consumer populace as well.

When the consumer populace is the senior citizen market, there is one marketing guideline that marketers must be quite attuned to. This guideline transends all grouping procedures and marketing strategies directed to specific clusters. To attain the balance, the viability, the harmony necessary for continued success in transactions, senior citizens must be treated with respect -- a special respect that relates to:

- their needs for security, and
- their need for self-esteem.

If that respect is given, we will be true to our discipline of marketing and live up to our roles as human beings trying to contribute to a harmonious society.

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Table 1
Mannerisms of Senior Citizens

| Personality | *Kansas City*<br>Mannerism | *Berkeley*<br>Mannerism |
|---|---|---|
| Integrated | *Reorganizer** | Mature |
| | *Focused* | Rocking Chair |
| | *Disengaged* | |
| Passive Dependent | *Succorance Seeking* | |
| | *Apathetic* | |
| Armored-Defended | *Holding On* | Armored |
| | *Constricted* | |
| Unintegrated | Disorganized | *Self-Haters* |
| | | *Angry* |

*Mannerism was included on the research form.

## Table 2
## Behavioral Mannerisms and Marketing Issues

| | Behavioral Mannerisms+ | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Marketing Issues | RO | FO | DE | HO | CS | SS | AP | DO |
| *Use "cents off" coupons | 58% | 28% | 33% | 57% | 36% | 53% | 50% | 32% |
| Select a store's own brand | 48% | 32% | 27% | 41% | 27% | 35% | 33% | 41% |
| *Try a new brand if there is one | 19% | 4% | 7% | 27% | 9% | 13% | 0% | 15% |
| *Buy the brand that is "on sale" | 69% | 52% | 53% | 60% | 46% | 41% | 100% | 50% |
| *Select the cheapest brand | 22% | 32% | 20% | 30% | 27% | 15% | 50% | 35% |
| Buy the same brand as last time | 86% | 84% | 93% | 76% | 91% | 90% | 67% | 85% |
| Believe higher quality products cost more | 70% | 72% | 67% | 68% | 73% | 77% | 83% | 85% |

+RO = Reorganized; FO = Focused; DE = Disengaged; HO = Holding On; CS = Constricted; SS = Succorance Seekers; AP = Apathetic; DO = Disorganize

*Significant difference at the .05 level of chance using a Chi Square test

## Table 3
## Degree to Which Behavior and Attitudes Describe Each Group
### Mean Scores by Group*

| Behavior/Attitudes | Reorganizers | Focused | Holding on | Disengaged | Succorance Seekers | Constricted | Angry | Apathetic | Self Blaming |
|---|---|---|---|---|---|---|---|---|---|
| 1. They are willing to adopt modern innovations. | 79.6 | 72.5 | 50.0 | 40.0 | 37.5 | 38.1 | 12.8 | 18.0 | 16.1 |
| 2. They are especially cautious when spending money. | 44.1 | 54.2 | 54.3 | 54.0 | 61.3 | 65.2 | 75.0 | 59.1 | 59.7 |
| 3. They are concerned with maintaining their appearance. | 74.2 | 78.4 | 83.9 | 54.8 | 60.2 | 58.8 | 36.2 | 21.1 | 26.0 |
| 4. They would rather be served than serve themselves. | 18.9 | 15.9 | 20.6 | 28.5 | 71.5 | 56.5 | 61.8 | 69.7 | 64.0 |
| 5. They frequently think about their health. | 40.3 | 39.0 | 59.1 | 43.0 | 75.1 | 87.7 | 62.8 | 69.2 | 67.6 |
| 6. They enjoy the physical pleasures of life. | 83.3 | 76.1 | 55.6 | 51.7 | 49.8 | 32.7 | 21.7 | 21.6 | 18.3 |
| 7. Friends are an integral part of their lives. | 85.4 | 78.6 | 55.9 | 51.4 | 67.4 | 51.6 | 22.8 | 19.6 | 19.8 |
| 8. They have a close relation with their children. | 75.8 | 76.5 | 54.2 | 48.4 | 62.2 | 53.8 | 23.1 | 26.8 | 22.2 |
| 9. They enjoy going out. | 89.4 | 82.1 | 64.3 | 45.2 | 53.2 | 41.4 | 24.6 | 14.0 | 20.2 |
| 10. They believe they are not respected. | 13.5 | 19.2 | 46.0 | 31.6 | 50.3 | 43.5 | 78.3 | 66.3 | 78.0 |

* The higher the score, up to a maximum of 100, the more the behavior or attitude describes the group.

### Table 4
### Relative Sizes of Adjustment Pattern Groups

| Group | Estimated % for Individual Groups | Estimated % for Cluster | | Adjusted* Estimated % for Cluster |
|---|---|---|---|---|
| Reorganizers (Healthy Adjustment) | 21.1 | 40.1 | = | 36 |
| Focused (Healthy Adjustment) | 19.0 | | | |
| Succorance Seekers (Fair Adjustment) | 13.2 | 24.0 | = | 22 |
| Constricted (Fair Adjustment) | 10.8 | | | |
| Apathetic (Poor Adjustment) | 7.1 | 17.2 | = | 15 |
| Angry (Poor Adjustment) | 5.4 | | | |
| Self-Blaming (Poor Adjustment) | 4.7 | | | |
| Holding On (Fair Adjustment) | 9.5 | 9.5 | = | 8 |
| Disengaged (Healthy Adjustment) | 9.2 | 9.2 | = | 8 |
| Unclassified | -- | -- | = | 11 |

*Adjustment based on unclassified participants in previous studies.

Table 5
Senior Citizen Profiles

| Clusters | Characteristics |
|---|---|
| Constricted | Health conscious, Appearance conscious, Price conscious, Happy, Reasponsible shopping, Influential, Self perceived leader, Not risk taker, Conservative, Low innovativeness, Detailed shopping lists, Saving stamps. |
| Reorganizer | Appearance conscious, Not price conscious, Happy, Don't enjoy shopping, Innovators, Social but not dependent on friends, Don't worry about health. |
| Disengaged | Not health conscious, Not appearance conscious, Price conscious, Happy, Don't enjoy shopping, Don't contact the few friends for advice, Not social, Watch TV, Conservative. |
| Succorance Seeker | Health conscious, Appearance concern, Socializers, Price conscious, Happy, Don't enjoy shopping, TV and friends, Reminisce about past, Buy new products. |
| Angry Apathetic | Price conscious, Not happy, Don't enjoy shopping, Not social and few friends, TV watchers, Not perceived leaders, Not innovators, Low risk takers, Dissatisfied with most of their past life. |

## Table 6
## APPROACHED AND APPEALS
## (Research Effort 2)

| GROUP | APPEALS |
|---|---|
| Reorganizer<br>Focused | Subtle presentation of physical enjoyment.<br>Pictures showing older and younger people as equal participants in activities. |
| Succorance Seekers<br>Constricted | Appeals stressing physical, societal and financial security.<br>Use of testimonials to reduce risk. |
| Apathetic<br>Angry<br>Self-Blamers | Strong rather than subtle presentation of appeals.<br>Use of bold print and sharp color tones to gain attention. |
| Holding On | Solutions to daily problems.<br>Concentrate on products that delay the appearance of growing old. |
| Disengaged | Being up to date.<br>Use of reason rather than emotion. |

### Table 7
### APPROACHED AND APPEALS
### (Research Effort 3)

| GROUP | APPEALS |
|---|---|
| Reorganizer<br>Focused | Show seniors in an active mode.<br>All media, but emphasize TV.<br>Products that are reliable and time tested. |
| Succorance Seekers<br>Constricted | Status appeals and respectability.<br>Print media as first above choice.<br>Products that improve appearance. |
| Apathetic<br>Disorganized | Convenience and efficiency appeals.<br>Strong emphasis on broadcast media.<br>Non-durable consumer goods. |
| Holding On | Value and health appeals.<br>Print media.<br>Leisure time products. |
| Disengaged | Loyalty and convenience appeals.<br>Broadcast media, especially TV.<br>Staples and essentials. |

### Table 8
### APPROACHED AND APPEALS
### (Research Effort 4)

| GROUP | APPEALS |
|---|---|
| Reorganizer | Show as meeting individual challenge.<br>TV as primary ad medium.<br>Products that are easily available since they dislike shopping. |
| Succorance Seekers Constricted | Show as respected for the wise advice they give others.<br>Ad media not determined.<br>Products that enhance personal appearance. |
| Apathetic/Angry | Show as enjoying safety by avoiding risks:<br>TV as primary ad medium.<br>Products that are low priced. |
| Disengaged | Show as value conscious while avoiding risks.<br>TV as primary ad medium.<br>Known products at reasonable price. |

Table 9
MEDIA USAGE SEGMENTS

| Segment | Characteristics |
|---|---|
| Skepticals (31%) | Used advertising to help in decision making but don't trust comparative ads. Believed that many ads insult their intelligence and would rather seek product advice from friends. Heaviest users of TV and newspapers. |
| Disbeliever (34%) | Had no favorable reactions about advertising. They used personal experience rather than friends' opinions in purchase decisions. Heaviest users of editorial and news magazines. |
| Believer (35%) | Used advertising information and did not consider it insulting. Did not often seek product advice from friends. |

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